THE PRESIDENT'S FISCAL YEAR 2009 BUDGET

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 13, 2008

Serial No. 110–69

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

47–927 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

THE PRESIDENT'S FISCAL YEAR 2009 BUDGET

WEDNESDAY, FEBRUARY 13, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 2:03 p.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (Chairman of the Committee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 06, 2008
FC–20

CONTACT: (202) 225–1721

Chairman Rangel Announces a Hearing on the President's Fiscal Year 2009 Budget for the U.S. Department of Health and Human Services

House Ways and Means Committee Chairman Charles B. Rangel today announced the Committee will hold a hearing on President Bush's budget proposals for fiscal year 2009 for the U.S. Department of Health and Human Services. **The hearing will take place on Wednesday, February 13, 2008, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be limited to the invited witness, the Honorable Michael Leavitt, Secretary, U.S. Department of Health and Human Services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

FOCUS OF THE HEARING:

On February 4, 2008, President George W. Bush submitted his fiscal year 2009 budget to Congress. The budget will detail his tax, spending and policy proposals for the coming year, including his proposed budget for the Department of Health and Human Services. Many of the Department's programs—such as Medicare, efforts to assist those who lack health insurance, and Temporary Assistance for Needy Families and other income security efforts—are within the Committee's jurisdiction.

In announcing the hearing, Chairman Rangel said, **"The President's budget calls for unprecedented deep cuts to traditional Medicare. We should be working together to strengthen Medicare for future generations, not undermining it," Chairman Rangel said in announcing this hearing. "Among the various proposed reductions in funding for low-income programs, President Bush's budget calls for the complete elimination of the Social Services Block Grant in 2010. Furthermore, this budget changes the tax code in ways that would erode health security and raise taxes for millions of American families. I hope Secretary Leavitt is willing to have an honest conversation about how best Congress and the Administration can work together to protect taxpayer interests and help all individuals and families get the social services and health care they need."**

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, email and ***ATTACH*** your submission as a Word or WordPerfect document to the email address provided, in compliance with the formatting requirements listed below, by close of business **Thursday, February 21, 2008**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Mr. STARK. We will commence our hearing on President Bush's fiscal 2009 budget. We are honored to have the Honorable Michael O. Leavitt, the Secretary of Health and Human Services for the U.S. Department of Health Human Services, to present to us today.

Mr. Secretary, Chairman Rangel is at the White House for the signing of the economic stimulus legislation. It is my honor to welcome you to the Committee. Having read your testimony, I don't know where to start.

Rarely have I seen an official document filled with so much misleading rhetoric and so few thoughtful suggestions. It is nothing short of disingenuous to claim concern about Medicare's future after what this Administration has done to the program.

The unfunded obligations that you cite were driven substantially higher by excessive corporate welfare provided to the insurance companies through both Medicare Advantage and Part D. While bashing the government, whom you and I are paid to work for, you say essentially that Medicare is a bad system and needs to be changed.

You decry price-setting, but offer no better way to control costs and ensure coverage. You suggest we rely on the private sector, but conveniently fail to point out that that system costs taxpayers far more than traditional Medicare, and we have no data to know what we are buying. The private sector, at least in Medicare, is neither transparent nor efficient.

You assert that government is making coverage decisions, but that is not quite true. In Medicare, physicians tend to drive medical care, and the program itself has relatively few coverage restric-

tions. Regardless, any of us who went through the Patients Bill of Rights debate can tell you that on the rare occasions when Medicare does make decisions, they are considerably more transparent and generous to patients than the arbitrary decisions too often made by private plans, whose priorities are profits and not patients.

Your budget takes a meat ax to a program that, together with Social Security, has substantially improved the health and financial security of American retirees. I predict it will be rejected by both parties.

Before I turn to Dr. McDermott, there is one thing on which we agree. With respect to Medicare, you wrote, "We need a change in philosophy, not just a change in the budget." I couldn't agree more.

Fortunately, we have only a few months left of this Administration, and then there will be a change. We need a President who is committed to protecting and improving, not dismantling, Medicare. That will be the real change from President Bush's desire to privatize a program that only exists because the private sector wouldn't take care of senior citizens in the first place.

Dr. McDermott, do you have an opening statement?

Dr. MCDERMOTT. Thank you, Mr. Chairman.

Secretary Leavitt, we had the pleasure of having the Secretary of the Treasury up here the other day, and I said that it reminded me of when Colin Powell went up to the United Nations General Assembly to sell the war. It is a heavy task that you have. I couldn't help thinking, as I read over this document, that Yogi Berra was right when he said, deja vu all over again.

We have seen this budget before a number of times, and you have been asked, among a growing list of people, to come up here and try and defend, I think, what is indefensible. It is because of your prior background that it is particularly troublesome to have you up here.

We have heard it before, but let me focus on one particular plan, and that is the plan to completely eliminate the social services block grant. Now, maybe younger Members don't understand how this works. But when Republicans get in charge, they always want to lump things together into block grants because it would be more efficient, and it will force efficiencies, and all this kind of stuff.

What they are really doing is lumping them together so they can chop them off little by little by little until they are gone. This budget that you put in front of us is a perfect example of why the social services block grant was a bad idea when it was put forward in the first place, because it funds today welfare services for 2.8 million abused and neglected children. It funds child care for 4½ million American children of working parents. It provides services to 1.3 million Americans with disabilities.

Now, to wipe that out is to simply drill a hole in the bottom of the lifeboat of an awful lot of people in this society. You knew it when you were governor because when you were Governor Leavitt in Utah, you once said, in your own words, "Vital human services for our most vulnerable citizens are provided by the social services block grant."

Now, you were right back then. That is why it is hard to have you up here today completely doing a reversal for the President. I

understand you are sent up here to do this, and I really—I respect your doing it. But it has got to feel a little uneasy doing it because you know.

The President wants the Congress to eliminate a program, but is really hiding it under the shell of the old rhetoric that we have heard again and again, your claim that we really aren't—in the documents—you really aren't cutting services to millions of children or seniors and families because other programs can do the job.

Now, really? Where are they getting the extra money for these programs? I don't see any programs that got any extra money, practically speaking, in the President's budget. Poverty is rising in the country, and the country may be headed into a recession, and all this budget says to our nation's most vulnerable families is, tough luck.

The social services block grant, in my view, is a lifeboat, and it is nothing more than that. You are out really to drill a hole in the bottom of it, leaving those folks at the greatest risk possible with states in recession, struggling to some way to come up with the money to fill the hole that you drill in the bottom of the boat with this kind of thing.

The National Governors Conference ought to be up here all over this place, whether they are Republicans or Democrats. Their ability to deal with child care and abused kids and all these things will take a serious shot from this kind of a budget.

It is really not compassionate conservatism. We heard that eight years ago. But there is very little evidence that I can see that this is anything but mean-spirited conservatism.

Fortunately for the people, I guess, Congress will shortly dump this in the waste bin. We go through this process of listening to you, and we will write our own improved version and fix some of the problems.

I yield back the balance of my time, Mr. Chairman.

Mr. STARK. Mr. Camp, would you add your kind comments to welcome——

Mr. CAMP. Well, thank you. I think they will be kinder than the ones we have heard so far.

Thank you, Mr. Chairman, and welcome, Secretary Leavitt. I want to commend you and thank you for your service to this country, and also to commend you for your efforts to draw public attention to the looming crisis facing the Medicare program.

Medicare costs continue to soar, and the premiums beneficiaries pay for Part B have more than doubled since the year 2000. Doctors face impending payment cuts that are likely to drive many of them away from treating Medicare beneficiaries, and the hospital insurance trust fund will be exhausted in just 11 years.

Given these many challenges, I would have preferred the Administration propose fundamental reforms that are needed to preserve Medicare. The 183 billion in payment reductions proposed by the President may help to alleviate the short-term financing issues, but I am concerned that they may not do enough to secure the long-term stability of this important program.

The President's proposals continue to rely on the same pricing system that has helped create many of the fundamental challenges now facing Medicare. Even if Congress were to immediately enact

all of the President's Medicare proposals, we would still have payment systems that underpay many providers, create perverse incentives to provide more and not better care, and distort the entire health care marketplace, as you and I have discussed in numerous meetings over the past year.

I think with this final budget, bolder ideas about how to transfer Medicare could have been put forward. I will say also that the Majority should not have wasted a full year of inaction on this pressing issue. We did not hold a single full Committee hearing on Medicare or Social Security, for that matter, both of which we addressed in the last Congress. So, we are wasting valuable time on this important issue.

This should have been an opportunity to discuss proposals like premium support for all Medicare beneficiaries, tying hospital payments to the value they provide, and providing more effective care to high cost Medicare beneficiaries. They are less than 20 percent of the Medicare population, but account for up to 80 percent of Medicare's total spending.

I hope, Mr. Secretary, that we can work with you in the time that we have left together to develop these ideas in anticipation of the looming national debate about health care. Mr. Chairman, I trust that you would be eager to join us in that effort.

I also want to thank the Secretary for his continuing efforts to encourage debate on how to expand private health insurance coverage, including the tax reform proposal that would insure up to 8 million more Americans. Our current health insurance system subsidizes employer-provided insurance and discriminates against workers solely upon the basis of where they work. Given the mobility in today's job market, not losing insurance just because you change jobs would be an improvement for all Americans.

I believe that any reforms we enact need to give individuals more control over their health care choices. We have seen in the new Medicare drug benefit, where beneficiaries have the right to choose among competing plans, Part D plans have been able to slow the rate of drug cost increases, and the costs of the program are now 40 percent below their original estimates, as you point out in your testimony.

The current health care system mandates that we take what we get, whether we need it or want it. Personal choices in the health care marketplace can lead to better consumer decisions regarding preventive care and help to reduce the rapid growth in national spending on health care.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. STARK. I would like now to recognize the gentleman from Illinois, the Ranking Member of the Income Security and Family Support Subcommittee.

Mr. WELLER. Thank you, Mr. Chairman. Mr. Secretary, welcome. Good to have you before the Committee, and appreciate the time you are giving us today.

I note the President's budget involving Income Security Subcommittee programs recognizes the fact that simply spending more money on welfare and related programs is not the same as actually solving problems. So, this budget proposes ways for states to use

current funds more flexibly to prevent problems like child abuse from occurring rather than simply treating the consequences of such abuse after it happens.

That follows the successful model of the 1996 welfare reforms, which increased work and earnings while at the same time reducing poverty and welfare dependence. These are precisely the sort of positive reforms this Committee should be reviewing because they promise better services and support for American families in need.

This hearing also provides an opportunity to review progress implementing welfare provisions in the Deficit Reduction Act of 2005, which extended and strengthened the pro-work policies included in the 1996 welfare reform law. As recent HHS data shows, welfare dependence is falling faster in the wake of that legislation, which is what Congress intended, to help more parents go to work and to support themselves.

So, Mr. Secretary, we welcome you before this Committee. We look forward to reviewing these and other important issues.

Mr. Chairman, I yield back the balance of my time.

Mr. STARK. Figure out these buttons here. Thank you, Mr. Weller.

Mr. Secretary, I am sure now in whatever manner you would like—we have your written testimony. It will appear in the record in its entirety. I am sure that in your verbal testimony, you are going to redeem yourself marvelously. Please proceed.

STATEMENT OF THE HONORABLE MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Thank you, Mr. Chairman. May I thank you for that cheery greeting, and also recognize that though we have different philosophies, I have always enjoyed our interactions. I have great respect for your intellect and your experience and the sense of public service that you bring.

I am here today to represent the President's budget. You will shortly begin to lay your hand to budget-writing, and I recognize that some of the decisions we have made may be different than the ones that you have. My job today is simply to do my best to describe why the President made the decisions that he has made.

I do desire to start with Medicare. It makes up 56 percent of the budget that I am representing today. It is also a very important program, and I do want to be clear with you and the American people that I care deeply about this. I care enough about it that I hope that your budget will be viewed as a clear warning. Medicare on its current course is not sustainable, and it is such an important part of the lives of so many of our citizens.

In 2007, the Medicare trustees' reported that the Hospital Insurance Trust Fund will be exhausted by 2019—that is 11 years from now—and that Medicare represents now a $34.2 trillion unfunded liability in our obligation for the Federal budget over the next 75 years.

I view this to be a very serious problem. I want to acknowledge the fact that American sensitivity to entitlement warnings has become somewhat numbed by what is a repeated cycle of alarms and

inaction. Those types of warnings have become an almost seasonal occurrence, like the cherry blossoms blooming every April. It is part of life's natural rhythm now. We hear the warnings, but we don't actually stop to think about what they mean or how important they are.

This budget, however, warns, I hope, in a different way. It illuminates with specificity the very difficult decisions that policymakers, no matter what party they are in, will face if we don't begin to reform and to change our philosophy. We can keep our national commitment, and must keep the national commitment we have to those who are beneficiaries of this program. But we do need to begin changing the way we manage the program.

Currently, Medicare's fee-for-service program, as you pointed out, is a centrally planned, government regulated system. I would characterize it as a price-setting system. Price-setting systems allow regulators to decide the priorities. Government decides in many cases the treatments that are provided and how much will be paid. We make decisions, a few thousand of them at CMS, that have a great impact on individual decisions in the medical life of many patients, millions.

Government tries to determine the value of those decisions based on procedures. It is a system that I think does not produce the right outcomes. Price-setting systems inevitably subsidize the wrong things. We overprice other things. A well-informed consumer, allowed to make decisions through an efficient, transparent market, in my judgment would make decisions that are more precise, and they would make decisions that are more wise.

One need look no further than the experience we have had with Medicare's prescription drug benefit, where government organized a market and then let consumers decide what drug plans work best for them. We are now entering the third year of that program. We see enrollment continuing to rise. We see beneficiaries highly satisfied. We see costs of beneficiaries and taxpayers consistently lower than originally projected.

Just last week, we announced that compared to the original Medicare Modernization Act of 2009 (MMA) projections, that Medicare's cost on the benefit will be reduced by $243.7 billion over the next 10 years. Beneficiaries have also saved. The most recent estimate shows that beneficiaries will pay, for a standard Part D coverage, at about $25. That is nearly 40 percent lower than we originally projected back in 2003.

There are lots of factors that led to lower costs. But competition has clearly been a big part of that. The plans have achieved greater efficiency than they expected. The retail prices have been negotiated better, manufacturers' rebates, et cetera. The program is working.

Now, I want to be clear that we prepared this budget with three major things in mind. One was long-term sustainability of Medicare because we do view it as so important. The second is affordability of premiums for beneficiaries. The third was to balance the budget.

Now, my time is up, and I don't want to go beyond that. You have my formal statement. I will get a chance, I am sure, to comment on various parts of it. But Mr. Chairman, I do want to reflect

on the fact that I care greatly about Medicare, and I want it to be around for every generation subsequent to this one. I look forward to a conversation as to how we can best accomplish that.

As you know, a person who is 54 years of age today in 11 years may not have the same stability that one does today. In October we are going to start selling bonds at the Treasury Department—to fund this deficit. We need to focus on it.

My time is up, and I will now look to your questions.

[The prepared statement of Secretary Leavitt follows:]

Testimony of

The Honorable Michael O. Leavitt

Secretary, U.S. Department of Health and Human Services

before the

Committee on Ways and Means

United States House of Representatives

February 13, 2008

Chairman Rangel, Congressman McCrery, and Members of the Committee, thank you for the invitation to discuss the President's FY 2009 budget request for the Department of Health and Human Services (HHS).

I wish to begin with Medicare, which makes up 56 percent of the $737 billion budget HHS presents today.

The Medicare portion of this budget should be viewed as a stark warning. Medicare, on its current course, is not sustainable. In 2007, the Medicare Trustees reported the Hospital Insurance Trust Fund will be exhausted in 2019 -- 11 years from now – and Medicare represents a $34.2 trillion unfunded obligation for the federal budget over 75 years. This is a serious matter.

Let's acknowledge that American sensitivity to entitlement warnings has become numbed by a repeated cycle of alarms and inaction. Such warnings have become a seasonal occurrence, like the cherry blossoms blooming in April, part of life's natural rhythm. We hear the warnings, but do nothing

This budget warns in a different way. It illuminates with specificity the hard decisions policy makers, no matter what their party, will face every year until we change the underlying philosophy. We can keep our national commitment to insuring the health of beneficiaries, but we need a change in how we manage Medicare.

Currently, the Medicare fee-for-service program is a centrally-planned, government regulated system of price setting. Price setting systems allow government regulators to decide the priorities.

Government's tools are blunt and inexact. Government decides which treatment to cover. Government decides how much treatment is provided based on how much government is

willing to pay for. Government tries to determine how much value different procedures have. It is a bad system and needs to be changed.

If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise.

One need look no further than our experience with Medicare's prescription drug benefit, where government organized a market and let consumers decide what drug plan worked best for them. Entering the third year of the program, we see enrollment continuing to rise, beneficiary satisfaction extremely high, and costs to beneficiaries and taxpayers considerably lower than originally projected.

Just last month we announced that, compared to original Medicare Modernization Act (MMA) projections, the projected net Medicare cost of the drug benefit is $243.7 billion lower over the 10-year period (2004-2013) used to score the MMA. Beneficiaries are saving as well. The most recent CMS estimate of the actual average premium beneficiaries will pay for standard Part D coverage in 2008 is roughly $25. This is nearly 40 percent lower than originally projected when the benefit was established in 2003.

While there are several important factors that contribute to lower costs, a key factor is that competition has been strong from the beginning of the program and the plans have achieved greater than expected savings from retail price negotiations, manufacturer rebates, and utilization management.

That said, however, using the blunt instruments we have available to us in other parts of Medicare, we have prepared a budget with three goals in mind: long term sustainability, affordable premiums for beneficiaries and a balanced national budget by 2012.

Some will be unhappy with this budget. While Medicare spending will increase by an average of 5 percent annually under our budget, they will see any attempt to slow the rate of Medicare's growth as a cut.

Our proposed budget includes a group of legislative and administrative improvements aimed at extending Medicare's viability for today's seniors and future generations. The slower growth rate they produce saves $183 billion over five years.

The proposals include:

- Encouraging provider competition and efficiency
- Promoting high quality care
- Rationalizing payment policies
- Improving program integrity
- Increasing high-income beneficiary responsibility for health care costs

The slower growth rate also reduces the premiums beneficiaries face by $6.2 billion over the next five years. Let me emphasize that generally, changes we make that reduce future government spending also gives a financial break to beneficiaries.

I mentioned Medicare warnings earlier. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress included a provision requiring the Medicare Trustees to issue a formal warning if two consecutive annual reports show that regular tax dollars exceed 45 percent of total Medicare spending within the current or next six years. I am a Trustee of the Medicare Trust Fund. Last year we triggered the alarm. As usual, there has been no action.

The same law requests the President propose legislation that will change the trajectory enough to bring general revenues back below 45 percent. We will formally respond to the trigger in coming days, but real solutions in Medicare will require genuine change in the way in which health care is conducted in America. And, if I can comment on that broader topic for a moment, let me say this:

There are two competing philosophies about the role government should play in health care. One is a Washington-run, government-owned plan, where government makes the choices, sets the prices, and then taxes people to pay the bill.

The other, supported by the Administration, is a private market where consumers choose, where insurance plans compete, and where innovation drives the quality of health care up and may drive the cost down.

The Administration believes every American needs access to health insurance at an affordable cost. In addition to its proposed tax reforms and health insurance market-based initiatives, the Administration believes the current health care system could operate more efficiently, without increasing federal spending on health care, if some portion of indirect public subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. The federal government would maintain its commitment to the neediest and most vulnerable populations, while giving the States, which are best situated to craft innovative solutions, the opportunity to move people into affordable insurance.

Before leaving Medicare, I want to make one more point.

I spoke earlier about the cherry blossom syndrome of entitlement warnings. Many may look at this budget and see the same old cherry blossom story – X billion of reductions here and Y billion there. But, as a Trustee of the Medicare Trust Fund, I ask that you concentrate on the condition of the Medicare Trust Fund. It is a story that needs to be told, and told, and told.

I have admired and appreciated David Walker, the Director of the Government Accountability Office (GAO) traveling the country sounding the warning. If my remarks today, describing the Department's budget, don't focus attention on this problem, then read his speech. Call the government actuary, or your favorite economist.

We are approaching an emergency. Real change in Medicare as a system is required, and soon. If you are 54 years old, and if Medicare is left on autopilot, when you turn 65 years old, Medicare will not be able to provide all the hospital insurance benefits promised under current law. We need a change in philosophy not just a change in the budget.

Now, on to other matters.

State Children's Insurance Program (SCHIP)

The President proposes to increase funding to states by $19.7 billion through 2013, with $450 million in outreach grants. Our proposal is consistent with the Administration's philosophy that SCHIP should be focused on uninsured, targeted, low income children first. It is also consistent with the position the President and the Administration articulated last fall. Our legislative proposal calls on Congress to address the issue of "crowd-out." It outlines State responsibilities when they expand SCHIP above 200 percent of the Federal Poverty Level, proposes enforcement mechanisms, and clarifies SCHIP eligibility by clearly defining income.

Medicaid

We are continuing our successful transformation of the Medicaid program. This budget request includes a series of proposed legislative and administrative changes. We propose legislative savings of more than $17 billion and assume administrative savings of approximately $800 million over the next five years while keeping Medicaid up-to-date and sustainable.

Food Protection

We have a good system of food protection in the United States, but as the global market matures, our systems have to change. Last year, we unveiled a new Food Protection Plan and proposed significant improvements in how we deal with imported products.

The President's budget increases funding for food safety by 7 percent, and the overall FDA budget by 5.7 percent. Eighty percent of the FDA budget pays for people. In two years, we will have added more than a thousand people at FDA. I mention that as an indication of how seriously we take the need to prepare aggressively for the future.

Biomedical Research

We have proposed increases for each Institute and Center at NIH. The overall budget will support 38,000 research project grants, including more than 9,700 new and competing awards. Overall, the budget will be the same as FY 2008.

Emergency Preparedness

Our nation remains at risk of terrorist attack and war. HHS is responsible to prevent and detect attacks, and respond to mass casualty events. Our budget proposes $4.3 billion to:

- Increase bioterrorism readiness
- Double advanced development of medical countermeasures
- Establish new international quarantine stations
- Expand and train medical emergency teams

We are seeking the funds necessary to complete our Pandemic preparedness.

One rather interesting part of our preparedness budget deals with ventilators. In many emergencies, especially terrorist attacks or pandemics, ventilators are needed to help victims breathe. Currently, ventilators cost $8,000 to $10,000 each. They also require specially trained teams to operate them. The combination of those two factors makes having an adequate supply nearly impossible.

We are requesting $25 million to develop the next generation of ventilators that are portable, up to 90 percent less expensive and do not require special training to operate.

Global Health

You will see a series of health diplomacy initiatives. Because threats to human health have become just as mobile as we are, our leadership in health around the world benefits Americans directly.

In addition to our work on HIV/AIDS, Malaria and Tuberculosis, we help other nations with disease monitoring and preparedness.

Conclusion

These are just some of the highlights of our budget proposal. Both the President and I believe that we have crafted a strong, fiscally responsible budget at a challenging time for the Federal government, with the need to further strengthen the economy and continue to protect the homeland.

We look forward to working with Congress, States, and all our other partners to carry out the initiatives President Bush is proposing to build a healthier, safer and more compassionate America.

Now, I will be happy to take a few questions.

Mr. STARK. Thank you. We can come back to a lot of the subjects that you have touched on. I suspect our principal difference—I happen to think that we are the only country in the world that doesn't set prices for the delivery of medical care. We are the highest cost, and only clock out at about 17th or 18th in outcomes, so that we don't have much to brag about there.

I just don't think that people shop or are able to shop for medical care the way they would shop for a Chevrolet or a Toyota or a new pair of shoes. There are those who think they can, but my guess is that that is beyond the competency of most pedestrians, and particularly beyond the competency of those who are in pain or in agony and need emergency care. They are in no position to shop. So, I tend to discount that.

But the private plans, as I am sure you are aware, the Medicare Advantage plans, cost the government a lot more than traditional Medicare. Do you know how much more, on average?

Secretary LEAVITT. I am aware that there are rates in certain areas—it varies by area—that are higher.

Mr. STARK. Thirteen to 20 percent higher. We have heard that the private plans will eventually cost less than the fee-for-service and yield savings. Why didn't you take advantage of these projected savings from Medicare Advantage in your budget?

Secretary LEAVITT. I can only reflect the fact that the actuaries were not prepared to score it, like they are not prepared to score a lot of things that I believe will ultimately occur in a market-driven system.

Mr. STARK. The chief actuary testified, didn't he, actually, before our Committee that there are never any savings under Medicare Advantage under the current law, and really no efficiencies in the system? Isn't that the situation?

Secretary LEAVITT. I believe there are changes that we can make to Medicare Advantage that would in fact hasten that. One example would be beginning to change the breadth of the competitive band. Right now it is county-by-county, and I don't think that is a good system. We ought to change it to where we have broader ranges of competition, and if we do——

Mr. STARK. Be glad to see what the actuaries have to say about that.

Secretary LEAVITT. I think it would be clear.

Mr. STARK. When you testified before the Senate Finance Committee, you stated that the plans cannot be subsidized indefinitely, and the subsidy was established so that a nationwide system could be developed. I think that is your testimony.

Any idea what kind of a timeframe you see on that, that we could end the subsidy for the Medicare Advantage plans?

Secretary LEAVITT. Well, the actuaries—not the actuaries on the policy. I would like to see immediate changes made on the range of competition that we have so we can open up like we did Part D. I am confident that if we were to change the system from focusing on a county-by-county basis and allow even for the bidding of those costs to be done on a state-by-state basis, that we would begin to see substantially more rigorous competition, and we would begin to see prices fall. I believe they would ultimately fall in the

fairly near term below the level of other regular Medicare fee-for-service.

Mr. STARK. Well, we look forward to any plans that you might put forward that the actuaries or others would suggest to us would save plans. My feeling is, and I really don't meant to lay this dead cat at your doorstep because I am not sure it was your idea, but I have said often and I don't know as I would get much disagreement, whether it starts back from Newt Gingrich or Ronald Reagan or wherever, that my feeling is that in privatizing, like encouraging people into Medicare Advantage, we could then pay a flat annual fee and get rid of our entitlement responsibilities and turn Medicare—I think this is the Republican plan—into a voucher program.

Then each senior would get a couple of thousand bucks, and they would go shop for whatever is in the market, which I think would end up putting us back into the pre-1965 era where there wouldn't be much available to them, although I am sure that your philosophy would be that, no, there would be a lot of plans open to them.

I don't want to put that to the test. You haven't convinced me yet. But would you agree with me that it is the Administration's long-range intent to try and, if privatize isn't the right word, do away with the entitlement features of Medicare?

Secretary LEAVITT. I think we would like to see Medicare Advantage look a lot more like Part D does. In Part D, we used the government to organize an efficient market, and we obviously made it available to every Medicare recipient. We gave people a choice. They could choose the plan that fits them best, and as I pointed out, we have not only seen dramatic reductions in the cost, we have seen people happy with it and we have seen enrollment go up. There is a——

Mr. STARK. Don't you think we could get those costs even down lower if we allowed you to negotiate prices?

Secretary LEAVITT. I don't believe government is an efficient—as good a negotiator of prices on an apples-to-apples basis. I don't.

Mr. STARK. Mr. Secretary, I think you would have PhRMA quaking in their boots if we were going to let you go out and negotiate with their clients. I have a great—boy, oh boy. I would want to bet on the side of how far you would reduce those prices.

I think Mr. Camp would agree. He is a hell of a negotiator, isn't he? I will let Mr. Camp go after him now. Thank you, Mr. Secretary.

Mr. CAMP. Well, thank you. Thank you, Mr. Chairman. You know, this discussion on Medicare Advantage, there was a study released last month by the Kaiser Family Foundation that found Medicare beneficiaries with the highest annual out-of-pocket costs in traditional Medicare could save thousands of dollars each year if they enrolled in Medicare Advantage.

For example, the study said that the sickest beneficiaries spend at least $6,353 in traditional Medicare, but those same beneficiaries would have spent only $2,160 in a coordinated care Medicare Advantage plan, for a savings of nearly $4,200. So, there are advantages, certainly, that we are seeing recorded in private sector studies that may not be reflected in actuaries.

But my question is: Since the majority has voted to cut 160 billion from Medicare Advantage, what would have happened to the

9 million beneficiaries currently enrolled in those plans if those efforts had succeeded?

Secretary LEAVITT. Well, you make the point, and a good one, that people like this. They like it a lot because they get better benefits. They have an opportunity to choose a physician. They don't have as difficult a time getting a physician. It is having a terrific impact among particularly low income and minority communities. People like Medicare Advantage and would be, I think, upset if it were to be removed from them.

I do want to make clear that I believe there are things we could do to enhance the competitiveness of Medicare Advantage, and we ought to because it is such an important part of the future of Medicare.

Mr. CAMP. I appreciate those Committees. I said as well in my opening statement that I think we need to look at the successes of programs like Part D and try to find a way to inject a similar structure into traditional Medicare.

You had mentioned a range of competition. Are there any other thoughts or details you wanted to mention about this type of reform?

Secretary LEAVITT. Well, I do want to make clear that when government negotiates, what government does is it begins to control the choices that consumers or patients make. If the government were negotiating the drug prices, for example, you would also have to give the Secretary the control of the formulary. I would have to make a decision on what drugs people could take.

I think consumers make better choices on what drugs they are going to take between them and their doctor than they do the Secretary of Health deciding and limiting their choices. So, there is a very clear give and take, and I believe consumers make better decisions than government.

Mr. CAMP. I know you have also been working on ways to make health care more accessible through the establishment of a new standard deduction, but also through your Affordable Choices. Can you describe for the Committee how the current tax system discriminates against workers without employer coverage?

Secretary LEAVITT. I think this is uniformly accepted by Republicans and Democrats, that the current code is blatantly discriminatory between those who buy insurance through their employer and those who buy outside the system. If a person outside the employment system were buying insurance through an employer-sponsored plan, they have to pay their taxes before they pay their insurance. It means that the biggest subsidy we give any person in America in the tax code is denied them.

As I work with states, who are working feverishly to try to give access to their citizens, this is the one problem they can't solve. If we could solve this for them by equalizing and taking the inequity out, there would be many states who would rapidly begin to assure that their markets were organized in a way that consumers could choose from low-cost plans that are available to them. If they can't afford it, then we could help them further. That is what the Affordable Choices would be.

Mr. CAMP. Wouldn't those choices among low cost plans provide more help to lower income workers?

Secretary LEAVITT. It would provide not only more help, it would give them more choices. They would be able to make decisions for themselves. We would be able to meet what I believe is our national goal, which is every American having insurance.

Mr. CAMP. How many currently uninsured would receive coverage under a proposal like the President's, which we have been discussing?

Secretary LEAVITT. Various estimates range, based on exactly how the law was written, but there are estimates that would have as many as 20 million people able to buy insurance who are currently not buying insurance.

Mr. CAMP. All right. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Mr. STARK. If I could just use up the last 30 seconds of your time.

We had this discussion last time, but I am sure you are both aware that under this deduction, automatic deduction of $7,500, which I gather is the same plan we had last year, that lower income workers would lose about 30 percent of their Social Security benefits as a result of their salaries being lowered by the deduction.

There was some talk with Secretary Paulson about fixing that, but I think it is important to notice that in addition to what else this might do, it would cut the Social Security benefits of the lower income workers.

The other comment that I wanted to add is that of the 34 trillion, which is a good calculation for dynamic scoring, but if we just did not cut the inheritance tax, we could cut half of that.

In other words, if you take the inheritance tax that is due to be eliminated—hopefully not—if it is not eliminated, we would pick up about 15 trillion in 75 years. If we did away with the whole Bush tax cut, we would have 100 trillion extra money in 75 years that would more than three times cover the unfunded obligations that you are talking about in Medicare.

Secretary LEAVITT. Well, raising taxes is always an option. It is not one we support, but it is always an option.

Mr. STARK. Just postponing the cut for 75 years.

Mr. Levin, would you like to inquire?

Mr. LEVIN. Welcome, Mr. Secretary.

As I read the budget, there is an assumption that Social Security would be changed to provide for private accounts. Is that correct?

Secretary LEAVITT. Actually, that is not part of the budget I am presenting today. Social Security is not in my portfolio.

Mr. LEVIN. So, you are not sure about that?

Secretary LEAVITT. Well, it is not part of what I am proposing today in this budget.

Mr. LEVIN. Is the Administration proposing it?

Secretary LEAVITT. Well, you would have to speak with those who have responsibility for it. I am not here to defend that proposal or to support it either way.

Mr. LEVIN. You know, under the tenure of this Administration, the poverty rate among children has gone up. In real dollar terms, NIH funding has been going down, in real dollar terms. I think that is part of the appalling feel of your testimony.

Dr. McDermott, Mr. McDermott, also talks about your suggestion to eliminate the social services block grant. I don't know what you replace it with. We are talking about kids—child welfare services, day care. I just find this appalling.

Let me ask you: You talk about basic philosophy, and you repeated it. Consumers make better decisions than government. On page 2, you say, "If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise."

What that essentially says is that over time, you would suggest the replacement of the present Medicare structure. Is that correct?

Secretary LEAVITT. What I would propose is that we find ways to improve the management of the system. I believe one way to do that would be to provide consumers with information about the cost and quality of their care, and that if they have that information, they will make very good choices. Because consumers want high quality and they want low costs.

Mr. LEVIN. Okay. But——

Secretary LEAVITT. One way to do that would be through Medicare Advantage.

Mr. LEVIN. So, essentially, your hope is that overt I mean, the present Medicare structure, the basic structure, would be replaced with private insurance?

Secretary LEAVITT. No. I think Medicare is a very important part of the social fabric of our country. I believe it would be better if Part A and B worked more like Part D.

Mr. LEVIN. That is private insurance.

Secretary LEAVITT. No. It is a government program.

Mr. LEVIN. Yes. But it is through——

Secretary LEAVITT [continuing]. That was organized by government to give people an opportunity——

Mr. LEVIN. It is a private insurance program.

Secretary LEAVITT. It is a program that is provided by private insurance companies, but it is a government-funded program and it is a government-provided program.

Mr. LEVIN. It is government-funded, but it is operated by private insurance. So, you essentially would replace the present system.

Secretary LEAVITT. I would like consumers to have the choice of being able to have a Medicare Advantage-like program.

Mr. LEVIN. Let me just say to you, I think one of the most mistaken statements that can be made is to talk about health care across the board and, "If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise."

Because you talk about 20 percent using 80 percent of the resources. These are people who have serious illnesses, by and large. Essentially, you are sitting here and telling people with the serious illnesses that consume most of these dollars for senior citizens that the decisions would be better made by them, that they would be far more precise and wise.

All I can suggest to you is that you go out into the countryside you have, and go back and try that. My hope is that this budget, this health budget, will be put up for a vote on the floor of the

House, and everybody have to vote yes or no on what has been proposed by you and the President.

I am going to make that recommendation, and see where people are with these massive changes, with these massive cuts, and let you defend——

Mr. CAMP. Would the gentleman yield?

Mr. LEVIN. Yes.

Mr. CAMP. I would be glad to put that up as long as it was also tie-barred with a vote to repeat Medicare Part D. We will see where the votes comes down on that as well.

Mr. LEVIN. No, no. I don't want tie-bar——

Mr. CAMP. What the Secretary is saying——

Mr. LEVIN. I will take back my time. Mr. Camp, we will decide what is tied to what because we are going to want you to vote yes or no on what has been proposed by this Administration and the Secretary, whom we respect personally, has come here to defend.

It will be interesting to see how many of you will vote for these changes. I hope that day will come. The reason I finish with this is I think it will help project this issue even further into a reasonable, responsible dialogue in the 2008 election.

Secretary LEAVITT. Mr. Chairman, could I respond?

Mr. STARK. Go right ahead, Mr. Secretary.

Secretary LEAVITT. Thank you. I would like to reflect the fact that at least I believe we could agree—I would hope we could agree—that the trajectory right now that Medicare is on is a dangerous one financially, and that we have to solve this problem for future generations—and we may have differences of opinion on how to do that. But I hope we could agree that this problem needs to be resolved.

I take no pleasure in being able to be the one who, in the context of a budget, makes decisions on what is basically a spreadsheet pro forma as to how I would rank the things that are the most important or least important. Some person with this system will ultimately have to make those decisions.

Mr. LEVIN. Let me just say, I agree with you something has to be done. Your medicine is worse than the illness. I agree there is a problem.

Secretary LEAVITT. Well, I think there is a better solution, and the solution would be to begin to change the system, where people have access to information about the cost and the quality of——

Mr. LEVIN. I am all in favor of information.

Secretary LEAVITT. I think we could agree on——

Mr. LEVIN. Not destruction of the program.

Mr. STARK. Mr. Herger, would you like to inquire?

Mr. HERGER. Yes. Thank you very much, Mr. Chairman.

Mr. Secretary, I want to thank you for coming before us, for being courageous, for recognizing a program that has incredible challenges to it, and being willing to go out beyond just a government control, which means well. But wherever we have total government control in any program any place in the world, well-meaning people, we just don't get the results. We get shortages. We get a lack of the care. We just don't get the results that we deserve here in this country and that people deserve any place.

I hear a number of concerns from my friends on the other side of the aisle that the Administration's budget would hurt Medicare. My fear is what will happen to Medicare if we don't take action soon to slow its growth? As you have mentioned, the unfunded liabilities of the Medicare program are estimated at $34.2 trillion. Now, that is a huge number, and it comes out to over $110,000 for every man, woman, and child in America.

I am concerned that if we continue to ignore this problem, it won't be long before Medicare disappears altogether. I am grateful that the Administration is responding to this crisis, and yet even this far-reaching budget proposal eliminates only one-third of Medicare's total unfunded liabilities.

Mr. Secretary, in your judgment, what needs to be done to get Medicare back on a solid financial footing?

Secretary LEAVITT. Well, thank you. I will answer your question. I would like to make the point that the reductions in growth that we are proposing will allow Medicare to continue to grow at 5 percent a year. Currently, it is growing at roughly 7.2 percent. So, we are simply slowing the rate of growth. We are not cutting anything. We are slowing the rate of growth. Now, I know Washington-speak. Everybody wants to argue about that as a cut. But the reality is, 5 percent a year over the next 5 years, more will be spent.

My view is that anyone, whether it is Mike Leavitt, George Bush, or any person who has to solve this problem, will ultimately have to do one of three things. They will either have to make hard cuts, or they will have to raise taxes, or they will have to find a way to begin allowing the system to be managed in a different way.

I believe the best way to manage it is to give people information about the cost and the quality of their services, and then let them choose. Let them make choices, not necessarily between care and no care, but choices between who provides the best quality at the best price.

Now, to do that, we are going to have to change not just Medicare but our health care system. It will require us to do, in my judgment, four things.

Electronic medical records need to be pervasive in our system to drive more efficiency. We have got to have better quality measures so our people know whether what they are getting is quality or not. We need to have price measures so that people know the price and they know the quality, and they are able to take the cost and the quality and make judgments. We know, from Part D, that if you give people good information and give them a choice, they will make choices that will drive quality up and the costs down.

So, this is not about leaving Medicare. It is about finding ways to improve Medicare so it is sustainable. A person who is 54 years of age today, when they turn 65, won't have a Medicare trust fund they can call on. We are this year selling bonds that are in the trust fund of Medicare Part A, and by the time we get 11 years out, they are gone and we will no longer be able to do that.

We are going to have to do one of two things: employ one of the tax-increasing methods that the Chairman has referred to; or we could do it with payroll tax, the way it is currently done; or we have got to change the system in a very thoughtful way. I believe

now is the time to do that. I do not support the idea that we simply do this with tax increases.

Mr. HERGER. Well, thank you. Mr. Chairman, I don't, either. I don't believe—I mean, at the rate we are going, we could not—at the rate this program is going, we could not raise our taxes enough in the long-term to be able to pay for all these entitlements that we have. We have to make the system work better and more efficiently. I want to commend you and the Administration for having the courage to move forward to attempt to do that. Thank you.

Secretary LEAVITT. Thank you.

Mr. STARK. Dr. McDermott, would you like to inquire?

Dr. MCDERMOTT. Mr. Chairman, thank you. Listening to Mr. Herger, I am very, very, very depressed. He has said that it is just not possible to solve this. I don't know, maybe the Finns and the Swedes and the Norwegians and the Germans and the Italians and the Dutch are smarter than we are.

Mr. STARK. The Irish?

Dr. MCDERMOTT. I guess that is what he was really saying. Americans—even the Irish have a national health plan. We can't fund ours. Somehow, they do. I guess they must be magicians, or else Americans, in Mr. Herger's view, are without the creativity and the ability to design a system that would work.

I find that very depressing. But I was reading my testimony—or your testimony and my questioning of you last year. My God, it is deja vu all over again. I said almost the same things last year. But last year, your answers were that the governors—that the problem was—because I said, well, you said, I was writing that when I was Chairman of the governors association.

I had that conversation with the governors, and I pointed out to them that there are categorical grants that every year they are using. It is not the most efficient way to deal with the states. You said, well, but they were in much better financial shape than when I wrote the letter. So, from the time you were governor to the time you got to be Secretary, things went uphill. So, you said, make some cuts.

Where are you today? How are the states doing today?

Secretary LEAVITT. Well, none of us are doing as well as we were two years ago, and we need——

Dr. MCDERMOTT. So, you cut the budget. You say——

Secretary LEAVITT. I had to——

Dr. MCDERMOTT [continuing]. States are in terrible shape in taking care of abused kids and child care and handicap, and you say, they are in worse shape but we are going to cut the money from the Federal Government. That is your answer to the states' problems.

Secretary LEAVITT. My answer is, we need to balance the budget by 2012, and we have to make hard choices. Within those are a number of programs that we can't——

Dr. MCDERMOTT. You think we could close one of the 800 bases that the military has? We have the largest military budget in the history of the world. We have more spent on military than the whole rest of the world combined. All we do is keep cutting the social programs.

The abused kids, they don't count. The kids—we want the mothers to work and we want child care and we want the schools to perform well, but we don't want to have decent child care. We don't want to pay for it. We are going to cut all that.

You are saying to the mayors and to the governors and the county executives all through this country: We don't care about the kids. We are going to keep piling it up over here, and as long as it is national security or the defense budget, it is a sacred cow. We can't touch it.

Secretary LEAVITT. I am sure you appreciate I don't have any defense depots in my budget. However, I do have a responsibility to bear my share of balancing the budget by 2012.

Dr. MCDERMOTT. You mean what the President——

Secretary LEAVITT. So, I had to go through and make decisions based on a whole series of what I think are redeemable, good programs to say, here are the ones that I think should be the highest priorities. That is what I have done. You may see it differently.

Dr. MCDERMOTT. But you are a good soldier. In that sense, you are a good soldier. The President says, Sergeant Leavitt, go out there and take that hill. You say, yes, sir. Here you are up on this hill. You are taking the hill.

Now, when you tell me that you are just slowing the growth—it is increasing 5 percent—but you are cutting a third of a trillion dollars out of the budget, the actuaries say that that money is for growing population and inflation. So, you are saying to them, look, cooks in my unit. We have one bag of rice here for food. I know that they have given us 100 more troops to eat. But you guys are going to have to eat that one bag of rice because I don't have the money to get you a second bag.

That is the solution of this Administration. It is the old story everybody knows from the fair about the guy who bought the horse. Feed it a bucket of oats, it will do fine. So, they fed it a bucket of oats. Well, the farmer said, gee, maybe I could get away with two-thirds of a bucket. So, the horse still pulled the wagon, so he fed it two-thirds. Then one day he fed it a third of the bucket. One day the horse died.

The problem with what you are proposing with cutting a third of a trillion dollars out of Medicare is you are trying to get the horse to die. You are trying to starve it to death. It is very clear what this Administration's plan has been from the start.

I yield back the balance of my time.

Mr. STARK. The distinguished gentleman from Texas, Mr. Johnson, like to inquire?

Mr. JOHNSON. Please. Thank you, sir.

I hate to hear all this talk of socialism and trying to be like some other countries that we know about. I will tell you, it doesn't work in those other countries. You guys ought to know that.

The President achieved some savings in his budget by tying beneficiaries' premiums——

Mr. PASCRELL. Mr. Chairman? Mr. Chairman, excuse me. I take exception to being—my comrades up here—I hope you don't take exception to the word "comrade"—being called socialists, Mr. Chairman.

Mr. STARK. Well, some of us——

Mr. LEVIN. I think that is absolutely out of order.

Mr. STARK. There are some of us who may get pretty close to that. So, let's not go down that road right now.

[Laughter.]

Mr. Johnson and I have come to an agreement on this. I am sure Sam will bail me out as we go along. Thank you.

Secretary LEAVITT. That is one of the most rewarding expressions of candor I have ever heard, Mr. Chairman.

Mr. JOHNSON. No. He and I do agree on a lot of things, believe it or not.

As I was saying, the President achieved some savings in his budget by tying beneficiaries' premiums for the Part D benefit to the beneficiary's ability to pay the premium. I agree that people like Ross Perot and Warren Buffett probably don't need the same help from the government to pay their health care bills as low income seniors.

I think maybe we ought to do away with the requirement to require people to enroll in Medicare just because they are 65 years old. Why hasn't the Administration allowed seniors the choice to opt out of Medicare Part A? Wouldn't that be a way to save some money?

Secretary LEAVITT. I don't know the answer to that. I think there is a general view that Medicare is a commitment we have made to seniors. The issue that we are talking about here is: What is the American system? Someone is going to have to make hard decisions. Should it be the government, should it be insurance companies, or should it be consumers who are armed with good information about cost and quality?

This is not a criticism I have simply of Medicare. This is a criticism I have about our system generally. In fact, I think you could argue in many ways we don't have a system. What we have is a large sector that needs a better sense of organization. The best organization would be giving consumers access to information about cost and quality, and allowing them to make decisions in an organized market.

With respect to Medicare and that decision, I don't know the answer to that.

Mr. JOHNSON. You are going to be made to get on Medicare when you get to be 65. Are you going to like it? I will tell you, I don't.

Secretary LEAVITT. I just had a birthday, and I am getting close.

Mr. JOHNSON. I would like to know if the Administration is prepared to send to Congress a proposal that addresses all these larger problems within the Medicare program. You probably realize that there was a 45 percent budget trigger. Are you going to send us something that takes that into consideration?

Secretary LEAVITT. Yes, Mr. Johnson. As you point out, the Medicare Modernization Act requires the trustees, of which I am one, to give notice if the budget is 45 percent or more from general revenue. We have met that trigger twice, the warning has been provided, and the Administration will be responding to that warning within the time limit allowed. We will be providing a proposal.

Mr. JOHNSON. Is that going to happen pretty quickly?

Secretary LEAVITT. We have until the 21st of February, and I have it on good authority we will do it before then.

Mr. JOHNSON. Well, you are on the board. You ought to be pretty good authority.

Secretary LEAVITT. Well, I think I am the authority on this one.

Mr. JOHNSON. I want to thank you for pushing the lessons of Part D. I think you are correct, totally correct, in that viewpoint. It distresses me that our nation can't stay on a businesslike proposal for Medicare, just like it does for a lot of other things. I thank you for your comments and thank you for being here today.

I yield back the balance of my time.

Mr. STARK. The gentleman from Georgia, Mr. Lewis, would you like to inquire?

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. Welcome, Mr. Secretary.

Mr. Secretary, let me just ask you a question first off. In your discussion and your meetings with the President and the OMB director, did you ever raise any question against some of these unbelievable cuts?

Secretary LEAVITT. You know, Congressman, there are lots of——

Mr. LEWIS OF GEORGIA. You are free to——

Secretary LEAVITT. There are lots of areas that I proposed more than what is reflected in this budget. But that is the way budgets are developed. We all come back with the things that we would both need, aspire for, and hope for. Then we whittle it down from there. This is the budget that the President——

Mr. LEWIS OF GEORGIA. Mr. Secretary, I must tell you, I shouldn't be surprised but I am surprised that the Medicare budget will destroy the Medicare program. $556 billion in Medicare cuts will destroy Medicare. We wouldn't know Medicare. Are you telling me that you didn't argue against cutting Medicare by $556 billion?

Secretary LEAVITT. Well, let me again reflect the fact that Medicare will continue to grow at more than 5 percent over the course of the next 5 years.

Mr. LEWIS OF GEORGIA. You are cutting hospitals. You are cutting the most vulnerable section of our society. Some of these hospitals are going to be forced to close. What is going to happen to the sick, the poor, the disabled, the most vulnerable people in our society? Are they going to fend for themselves? Are you suggesting that we should just end Medicare and just give everybody a check?

That is what you were suggesting that may take place, Mr. Stark. Is that the road we want to go down?

Secretary LEAVITT. Clearly not.

Mr. LEWIS OF GEORGIA. Are we in the boat together? Are we all in the same boat?

Secretary LEAVITT. We are. We have a commitment that we have to meet.

Mr. LEWIS OF GEORGIA. Well, shouldn't we look out for each other?

Secretary LEAVITT. Absolutely.

Mr. LEWIS OF GEORGIA. Well, I don't think this budget is a reflection of that.

Secretary LEAVITT. Well, this budget is a reflection of a concern we also ought to share, and that is that in 11 years, it goes broke. We have to do something to fix it.

Mr. LEWIS OF GEORGIA. Are you trying to end Medicare?

Secretary LEAVITT. No. I want it to survive——

Mr. LEWIS OF GEORGIA. Is this the goal? Is this the plan? Is this part of the timetable, that this Administration wants to end Medicare as we know it?

Secretary LEAVITT. Well, the same question could be asked about those who refuse to do anything to change it. Because we are going to run out of money, Mr. Lewis, in 11 years, and if we don't start now to begin to reshape the system in a way that it can be sustainable, the accusations that you render would become, by their nature, true. We want that not to happen. We want this to be sustainable——

Mr. LEWIS OF GEORGIA. My colleague——

Secretary LEAVITT [continuing]. Available to help people who are poor.

Mr. LEWIS OF GEORGIA. Mr. Secretary, my colleague here, Dr. McDermott, is a learned scholar. He is a doctor. He knows all about the area of medicine. He is suggesting maybe we should consider closing some of our bases. We don't cut the defense budget.

Someone who is in charge of these programs, you don't tell me that you cannot stand up and argue with the President, argue with Mr. Nussle, and say, this is not the road we should go down?

Secretary LEAVITT. I advocate forcefully the views that I have in the budget process. The President and Mr. Nussle obviously make decisions that begin to make allocations. Once those allocations are made, then we do our best to shape the budget in a way that will provide the best and maximum amount of good.

I believe Medicare is a very important part of the social fabric of this country. I believe that we have made a commitment that if a person is elderly, if they are disabled, if they are poor, or if they are in some other way in need, we need to help them. We need to make certain that those programs are sustainable over a lengthy period of time.

Right now this program is not. I might add, neither is Medicaid. Unless we change it, we will have difficult problems. The solutions will be so harsh, I worry that people won't fix it. I want to fix it now while we can.

There is a point in the life of every problem when it is big enough you can see it and small enough you can still solve it. We are getting darn close to the point that this one is unsolvable. We need to act now.

Mr. LEWIS OF GEORGIA. Mr. Secretary, I must tell you that I am deeply troubled, and I fear for the American people, for our sick, the disabled, our children today. I think we can do better. I think this budget is not a budget of compassion. I think it is mean-spirited.

Thank you. Thank you, Mr. Chairman.

Mr. STARK. Mr. Weller, would you like to inquire, sir?

Mr. WELLER. Thank you, Mr. Chairman.

Mr. Secretary, I always enjoy listening to my good friends on the other side of the aisle. My good friend Mr. McDermott made ref-

erence to increases in child care funding. I would note for a historical fact that in the 2005 Deficit Reduction Act, which went into effect in 2006, that it contained the last ever increase in child care funding.

In fact, we had a vote on increasing child care funding by $1 billion, and unfortunately, I noted, even though it went into effect, it was passed on a party line vote. Mr. McDermott and his Democratic colleagues on the other side of the aisle voted against, the last time we ever had a vote on the floor, to increase funding for child care. I just want to note that for the record.

You know, in 1996 the welfare reform legislation—which was passed by a Republican Congress and signed into law by a Democratic President; it is lauded for an act of bipartisanship—proved a tremendous amount of success. I would note that it was 12 years ago that that was passed, and of course, the impending doom of the Medicare trust fund is 11 years. Right? So, that is actually a shorter period of time. So, it shows we do need to act to find ways to do a better job with the resources we have available.

That is the point I would like to focus on, Mr. Secretary. As welfare reform showed, you don't show compassion by how much money you spend. It is how well you spend those dollars to get the results that help people.

I am interested, Mr. Secretary, if you can outline for us how the President's budget spends the resources we have in a smarter way, more efficiently, helping the people who need help. If you can walk us through those initiatives, Mr. Secretary.

Secretary LEAVITT. Well, you mentioned child welfare. The flexibility that would be provided under the child welfare option that we have in the President's budget would improve child protective services. It would allow the states to receive their Federal foster care funds in a fixed and flexible stream instead of waiting to receive the funds only after they have removed a child from the family.

Under the option, states would receive these funds to spend on child welfare activities as they choose. We would encourage them to invest these dollars in evidence-based proven prevention activities. That is one example.

Mr. WELLER. Why is prevention important when it comes to child care?

Secretary LEAVITT. Well, it is the same as health care. If we spend all of our time treating the patient after they are sick, it is very expensive and there is a lot of human suffering. If we prevent, there is less cost and we avoid a lot of human suffering and long-term costs. I think all of us know that preventing is the answer and not just picking up after it has occurred.

Mr. WELLER. What I see as one of the problems we have often in Washington is there is a Washington knows best attitude, telling states how they should administer programs. This budget, I know, from what I have seen, really emphasizes flexibility.

You have been a governor. Can you explain, from the perspective of having been a governor, how flexibility can actually help us make sure those dollars are spent in a better, more effective way in helping people?

Secretary LEAVITT. Well, I think two programs, one you spoke of, welfare reform, when we went to the TANF system. We gave states essentially a set of expectations and allowed them to design programs that would in fact solve the problem. They have, and it has dramatically reduced the amount we spend, the number of people on it, and people view it as a milestone in the delivery of human services.

I think another is Part D Medicare, where the states weren't involved in that, but we provided flexibility.

Another good example with the states is the SCHIP program. Many of the states have managed their SCHIP program in a way that has provided for dramatically more children to be on the program than if they just used the regular Medicaid system that is prescribed or would be prescribed by the Federal Government.

Mr. WELLER. Well, thank you, Mr. Secretary. I see I have run out of time.

Thank you, Mr. Chairman, for the opportunity to question.

Mr. STARK. Any time, Mr. Weller.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Mr. Secretary, thank you very much for being with us. Good to see you again.

Let me try to focus my questions a bit. I would like to chat with you a bit about the cuts and how they seem to be focused in certain areas. First, it seems that you—well, first let me ask: You signed off on this budget before it got to the White House for clearance with the Office of Management and Budget for submittal to Congress?

Secretary LEAVITT. We go through a budget process where my various operating divisions submit budgets to me. Acting with guidance from the White House, we develop our recommendations. They go down to the White House. They make suggestions and decisions. We then go back and appeal.

Mr. BECERRA. So, this Medicare budget within the President's overall budget, you concur with?

Secretary LEAVITT. I concur clearly that we have to do something to solve this problem.

Mr. BECERRA. No, Mr. Secretary. My question is——

Secretary LEAVITT. Now, let me finish. Let me finish.

Mr. BECERRA. This budget that has been presented—well, let me be more specific. Do you agree with all of the different cuts to Medicare that are in this Bush budget that is presented to Congress?

Secretary LEAVITT. First, there are no cuts. There is a reduction in the growth rate. We will see Medicare grow by 5 percent.

Mr. BECERRA. So, let's call it reduction in the growth rate. Do you agree with all the cuts to the growth rate in Medicare that are in this budget?

Secretary LEAVITT. If you are asking if I believe that there is a better way to do this, I do. But it is not available to us in the government price-setting world we live in.

Mr. BECERRA. Now, Mr. Secretary, I understand all that and I don't—what I am trying to do is get as specific as I can. I understand that there are qualifications to anything. Forgive me if I try to have you be as specific as possible.

I am trying to identify whether there are any—I call them cuts; you may call them a reduction in growth rate—but if there are any cuts that you disagree with in this budget.

Secretary LEAVITT. This is the President's budget. I am here to defend his budget. Are there those that I would have done slightly different? Of course. But he is the President, and——

Mr. BECERRA. Are there any that you can identify for us?

Secretary LEAVITT. Well, I am here to defend the President's budget, and I feel good about defending it. I will tell you, and I want to reemphasize——

Mr. BECERRA. Now, Mr. Secretary, let me move on.

Secretary LEAVITT [continuing]. This is a blunt instrument. There is no way you can do this with precision in the system we have. That is the problem I have with the system. When I said to Mr. Stark, I would like to see the system change, I would like to see a system that isn't—where we don't create a budget with such blunt instruments. Somebody someday is going to have to deal with this.

Mr. BECERRA. Fair enough.

Secretary LEAVITT. You may not like mine, but someday somebody is going to have to make these decisions.

Mr. BECERRA. That is fair enough. I appreciate what you are trying to point out, is that we do have an issue that must be addressed that is a long-term issue that, if we don't address sooner than later, becomes very big later on down the line. I don't think anyone disagrees with you there.

It is just that a number of us believe that this budget doesn't do anything to improve the situation by making a lot of seniors face some pretty devastating cuts. You may call them reductions in growth rate, but to a senior who has to pay more this year for that medication that may be lifesaving than he or she did last year, not getting an increase in that Medicare payment for that physician prescribing that medication or for the medicine itself amounts to a cut, which that person now has to come out of pocket to pay or somehow has to figure out what to do, either that or not get the medicine.

So, what we may call here as technocrats a reduction in the growth rate is, to most living and breathing human beings who receive Medicare benefits, a cut.

With regard to hospitals, it seems like this budget—and I will say this budget; I won't say you, Mr. Secretary—this budget punishes hospitals more than any other provider of medical services to our senior population. In particular, I am shocked at the level of precision of the hit that goes to children's hospitals, in this case, children's hospitals through the graduate medical education payment that they get.

I know in California we have about 25, 27 children's hospitals. I know that there are several throughout the nation, tens of children's hospitals, who do yeoman's work. Many times these families don't have the money that it takes to provide the lifesaving services that they receive for their children. In many cases, the children have miraculous recoveries.

But the millions of dollars that you take out of the hides of these children's hospitals, I don't see where they make it up. You don't

provide anywhere in the budget where they would make it up. I hope you will take a look at that.

Also what disturbs me is the teaching hospitals. The hospitals that are willing to educate the next generation of medical leaders are going to get hit dramatically in this budget. You almost force them to go away from teaching and into more of a profit-making mode by just taking patients through a mill process.

Because they can't make money when they are trying to educate the next class of doctors and providers if they are not getting reimbursed for that, and we know that most of these teaching hospitals actually provide health care to a lot of poor and indigent—I mean, indigent and minority populations.

So, since my time is expired, I will leave it at this and say, Mr. Secretary, I hope that you will counsel the White House and really urge upon them that we reexamine some of these proposals for reductions in growth because I think those reductions in growth are going to devastate, through their cuts, a lot of very dignified seniors who thought they had worked a long time for their Medicare benefits, and now find that the government is leaving them behind.

So, I thank you for your time.

Secretary LEAVITT. Congressman, can I just respond that I acknowledge that there are a number of places here where you might make decisions that are different than what the Administration has. However, whoever it is that ultimately has to deal with this problem will have to make similar decisions.

What I am here to argue is that the time for us to just argue about what price-setting measure we are going to use or not use, how much we are going to increase this or that, is not as good a system as we could create if we began to modernize health care as well as Medicare and give information to people where they can make decisions that will allow the invisible hand of the consumer to begin to drive priorities.

It will ultimately get to it. I fully acknowledge how difficult many of these things are. It is the reason I said I hope this is a very clear warning that somebody has to make these decisions. Right now we are not making them.

Mr. STARK. Mr. Brady, would you like to inquire?

Mr. BRADY. Thank you, Mr. Chairman.

Mr. Secretary, two questions, one about Medicare fraud, the second about IVIG. It seems like every week we open up the newspaper and see some major fraud case—medical devices, scooters, physicians who don't exist, patients who weren't treated, and on and on.

Do you have any estimates or studies that quantify just how much we lose to Medicare fraud each year?

Secretary LEAVITT. Studies have been made, and those are available. I would be happy to provide them to you independently. I don't have them on the top of my head. I will tell you this: I have personally been involved in operations we have had to find and to remedy this.

One of the big disappointments to me of the 2008 budget, frankly, was the $300-some-odd million that was in the budget for antifraud was taken out. We get a 13 to 15 times return on those dollars. I hope that the current budget will not make that mistake.

This is money that we need in order to keep people from defrauding seniors.

Mr. BRADY. So, Congress—are you saying Congress cut the funding for anti-fraud?

Secretary LEAVITT. It was in the budget and then was removed at the last minute for reasons I don't fully understand. But it has hurt our capacity to stop fraud.

Mr. BRADY. Well that doesn't make sense because it seems like the fraud is significant. They are just ripping off our seniors when they do that. We don't have enough money to go around——

Secretary LEAVITT. Every dollar we put into this, we get 13 to 15 back, and it gives the system more integrity. We need to focus more money on this.

Mr. BRADY. I hope this Committee leads the way in providing you the resources you need.

Second question. I raised this last year. We have talked to your office and agency frequently about this. The issue of IVIG deals with the treatment for those without an immune system in their bodies. The reductions we have had here in the past year have made it almost impossible for these patients.

There are not a lot of them, 10,000 or so, if I recall, who now are being almost forced to go into the hospital to receive treatment, which for someone without an immune system, the worst place in the world to be is a hospital setting.

I know that we have introduced legislation and worked with your office to treat this, much like Medicare has treated the hemophilia clotting factor, where you recognize it as a unique biologic product that requires a modified Part B reimbursement policy.

Mr. Secretary, would you and your colleagues at CMS be willing to work with me and other Members of this Committee to finally address the issues surrounding IVIG? I understand the need to try to get the best bang for our buck. But this actually, I think, is an awfully bad move. I don't want to see it be made even worse going forward.

Secretary LEAVITT. The answer is yes. I am aware of the problem. In fact, we have recently developed an inter-agency workgroup to be able to work with FDA and CMS and others. So, the answer is yes.

But could I point out that this is a great example of the difference between Part B and Part D? We don't have this dilemma in Part D because consumers and doctors are making decisions about this. We have it in Part B because we are having to have a government price-setting decision. There are differences of opinion that are going to be playing out here.

We will work this problem out, but it is a very good example. We don't have this kind of dispute in Part D. We do in Part B.

Mr. BRADY. Well, I will take you up on your offer because just for these people, it has been very frustrating. There has been good bipartisan support on this Committee to modify the reimbursement. We have worked with the Senate on it. There seems to be agreement that the cost of it is very small, but the importance to those patients is huge.

So, I would like to see—and the sooner the better, obviously, for all of them. So, thank you, Mr. Secretary.

Secretary LEAVITT. Thank you, Mr. Brady.

Mr. BRADY. I yield back, Chairman.

Mr. STARK. I just wanted to respond again to my good friend from Texas that I would like to join with him to help and see whether we could get some kind of a solution to it. It is very expensive. Individual doses are $5-, $6,000. But for people who need it, it is very important.

Mr. BRADY. Thank you, Chairman.

Mr. STARK. I would be glad to work with you.

Mr. BRADY. The good news is I think we just got a recent score on the modification, and it is very small. But thank you.

Mr. STARK. Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman. Thank you, Mr. Secretary.

Mr. Secretary, as you are most familiar, this Committee and the House approved significant improvements to Medicare last year in the CHAMP Act which were paid for by reducing by $50 billion over 5 years the subsidy to private insurance carriers in the so-called Medicare Advantage program.

You and the Administration opposed paying for it in that manner, and when the Senate, considering our legislation, proposed an amount to come out of the private insurance company subsidy that was less than that $50 billion, the Administration threatened to veto it if there was a substantial amount taken from the private insurance company subsidy.

Does that remain the position of the Administration today?

Secretary LEAVITT. The Administration is a big supporter of Medicare Advantage. I have indicated earlier that I personally believe that there are things we can do to improve its——

Mr. DOGGETT. Yes, sir. I am going to ask you about that. All I need to know now is: Your position hasn't changed, has it?

Secretary LEAVITT. We believe Medicare Advantage is an important component of Medicare, that people like it, and we are not——

Mr. DOGGETT. You don't want money taken from it in order to improve traditional Medicare?

Secretary LEAVITT. We believe that it is an important part and needs to continue. We believe that it is important that it is nationwide, and that the system that was established was done so to make——

Mr. DOGGETT. I will accept that as a yes. You are aware also that as you discussed with Chairman Stark, that the subsidy amounts to about a thousand dollars per beneficiary this year, according to everybody who has looked at it. It is a significant subsidy for each beneficiary, more expensive than under traditional Medicare to be in the Medicare Advantage program. Right? That is not——

Secretary LEAVITT. I am sure that we would agree that 80 percent of those go to the beneficiary.

Mr. DOGGETT. That is not a new subsidy. In fact, as I look back through the proceedings of this Committee going all the way back to 2004, when my colleague Max Sandlin from Texas asked the actuary if there was any verifiable savings to be had at any point in these plans, and he said no.

That hasn't changed through 2004, 2005, 2006, 2007, 2008. We are up through this ideological experiment of relying on privatizing Medicare. It costs us a thousand dollars a beneficiary, per person, last year. Neither you nor anyone in this Administration can point to any objective, verifiable savings that have come from that.

Secretary LEAVITT. I earlier today pointed out the fact that I believe if we were to expand the bands of competition, we would——

Mr. DOGGETT. All right. I want to talk to you about that. But the answer is no. You can't show us any verifiable savings. You think that maybe if you change the plan, you could get those savings. Right?

Secretary LEAVITT. I think it is an important part. Medicare Advantage is an important part. People like it. We need to expand it because it in fact gives people choices.

Mr. DOGGETT. So, I will take your non-answer as an indication you have no savings. You think the plan should be changed. Where is your legislation to change the plan?

Secretary LEAVITT. I believe it is very clear that the——

Mr. DOGGETT. I am sorry. Where is it? Do you have it with you today?

Secretary LEAVITT. I do not.

Mr. DOGGETT. Which one of the Republican Members of this Committee has authored legislation to change Medicare Advantage?

Secretary LEAVITT. Mr. Doggett, I am not sure I——

Mr. DOGGETT. In the fashion that you recommend?

Secretary LEAVITT. Well, we are having a discussion today about the philosophy, not the specific legislation.

Mr. DOGGETT. Well, we are having a discussion after 8 years, almost, of this Administration in which we have subsidized and had an incredible amount of waste in subsidizing private insurance, an ideological experiment. We have no verification that it saves the taxpayer a dime.

You tell us, well, maybe we can't prove it saved anything, but I got an idea that if we change it a little this way or a little that way, we could start having the savings that make up for these billions of dollars that have been wasted. Neither you nor anyone in the Administration or any of our colleagues on the Republican side has that legislation after 7 or 8 years. So, I don't find it very substantive.

Let me ask you about another example of the waste that this Administration has tolerated. You have been boasting if we would just be a little bit more like Part D, things would be wonderful. Well, I refer you to the Inspector General's report from your Department about how Part D has worked.

They point out that Medicare only overpaid the Part D private insurance companies $4.4 billion for the year 2006. That is a little bit of change, $4.4 billion, and that it took Medicare under its procedures 9 months to even figure it out.

Is that an example of what you think is a good treatment of the taxpayers' money in managing Part D with these private insurance carriers?

Secretary LEAVITT. Both of those procedures were contemplated in the law and were done in accordance with what we expected——

Mr. DOGGETT. According to the law that you recommended and that this Republican Congress before us approved over our objection in the middle of the night. Yes, sir, it is.

Secretary LEAVITT. A law that——

Mr. DOGGETT. As a result of that, we get private insurance companies getting $4.4 billion, and 9 months before Medicare even figures it out. How much interest have you gotten back from them on that $4.4 billion that they got for 9 months, plus whatever time it took you after you figured it out to get it back?

Secretary LEAVITT. Congressman, this is a program that 86 percent of the people who have it like it. This is a program that 40 percent——

Mr. DOGGETT. It is a program that the taxpayers——

Secretary LEAVITT. Excuse me. This is a program——

Mr. DOGGETT. $4.4 billion. Not a penny of interest have you gotten back from it.

I asked last June and again in October—we have submitted it in writing; we have asked it orally—to tell us what happened to the $100 million that you wasted in paying private insurance companies for retroactive coverage for low income beneficiaries that they were never told about until too late to take any advantage of it.

I still don't have an answer. The Subcommittee doesn't have an answer to its written questions. Do you think before you come to testify before the Budget Committee this week or next, when I get a chance to ask you about this again, that you could please bring us those answers that have been due since last summer?

Secretary LEAVITT. That seems like it would be a smart thing to do.

Mr. DOGGETT. Thank you.

Mr. STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Mr. Secretary, I want to ask you not just about the budget; I want to ask you about some rules that have been promulgated by HHS. I know it is a budget hearing, but we don't get you up here often, so it is a chance to do that.

The rule I want to ask you about was proposed on August 31, 2007. It would exclude from Medicaid or SCHIP matching grants any payments under state plans that use school personnel to help enroll children that might be eligible for either SCHIP or Medicaid.

I just want to talk conceptually with you about this. I don't know if you mean to be mean-spirited or if this is kind of just inadvertent, an inadvertent consequence of a badly conceived rule. First let's see whether we have some values agreements.

I believe that you would believe that enrollment of those eligible, enrollment of children eligible for Medicaid coverage or SCHIP coverage, is a positive feature as states work these programs. Is that correct?

Secretary LEAVITT. They clearly are.

Mr. POMEROY. Clearly. I believe that you would think that the school was a pretty good place to do that. There was a specific report, in fact, put out in 2000, the last Administration: HHS, U.S. Department of Agriculture, and the Department of Education, that pointed out that schools are where the children are and represent

the "single best link" for identifying and enrolling eligible low income children in health coverage.

Do you agree that the schools are a very good place to identify and enroll children?

Secretary LEAVITT. Clearly they manifest themselves, and that that is one of the sources.

Mr. POMEROY. You know, the success of these programs is evident in your hometown, Salt Lake City, or the town you previously lived in. I don't know if that is where you were born and raised or not. But the Granite School District there, just as an example, reaches out to children to identify and assist those who qualify for Medicaid or SCHIP. They have got two full-time and two part-time people involved in this, and each year they submit about a thousand apps for Medicaid, and about 77 percent are enrolled, which is a very favorable enrollment rate.

Now, under your plan, you would eliminate funding for those school personnel working through the Granite School District. Now, what would be the rationale for taking a step like that?

Secretary LEAVITT. The dilemma we have faced with Medicaid in many ways is that lots of places don't get the budget they need for many purposes. I am not specifically aware of what you are referencing. But I can tell you what we are eliminating, and it is the non-medical—I mean, there are school districts, Congressman, that buy school buses with Medicaid dollars.

Mr. POMEROY. I mean, I think that is appalling. That has got nothing to do with enrolling people in Medicaid or SCHIP.

Secretary LEAVITT. Well, that's right. That is what we are trying to——

Mr. POMEROY. The Department, without objection from this Committee, put forward a rule in 2003 to address that.

Secretary LEAVITT. Our effort in dealing with these targeted case management rules is to be able to assure that we are paying for medically necessary things and eliminating what we believe to be misuses. There is nothing mean about this. We are looking to find a way to preserve the dollars——

Mr. POMEROY. Maybe you don't have this information. I actually would appreciate it, if you don't have it, get me information. If the 2003 rule fell short of preventing abuses, where did it fall short? Because what you have now done is something quite different.

You have prohibited any Federal funds to be used on school personnel. You do allow Federal funds to be used for contract personnel. So, let's say Halliburton today is in the business of some kind of school outreach activity. I don't know whether they do this or not. But you would happily pay the Halliburton-type contractor, but not the school district, including, for example, the Granite School District personnel who have been so successful in Salt Lake City in getting poor children enrolled for the coverage they need.

So, I believe this has been an extremely ill-advised thing the Department has advanced. Congress has put a moratorium on it as they reauthorized SCHIP. But it is only a temporary one, and it to me would appear to be something the Department continues to move forward.

Secretary LEAVITT. Congressman, I want you to know—I am not able to respond to the granularity of what you are talking about. But I do have some knowledge of both what happens on the ground and what we are trying to accomplish.

There is a robust industry of consultants who will use every possible means of being able to find ambiguities in the law and to parse them so that various entities that are not medical providers, that are not part of the medical system, can tap into Medicaid funding. It distracts from our original mission and purpose. I would be happy to respond with more specific information.

Mr. POMEROY. I would respond to you that there are also special education teachers that are dealing with children in schools today with developmental disabilities, some of them medically related. Some of those children are from families that don't have coverage, and they can't get access to doctors because their families can't afford it.

You would prevent this school teacher from bringing this family——

Secretary LEAVITT. No. I would not prevent that school teacher. What I would prevent them from doing is paying for the teacher.

Mr. POMEROY. You would prevent any compensation to that school district for——

Secretary LEAVITT. No.

Mr. POMEROY. Yes, you would. Yes, you absolutely would.

Secretary LEAVITT. We are not doing that. No, we are not. Congressman——

Mr. POMEROY. You would prevent the payment to that school district for any assistance in helping that special education teacher get the epileptic child that needs the medication that they can't afford because the family doesn't have coverage—you would prevent that by rule.

Secretary LEAVITT. Congressman, you are pointing your finger at me and ascribing motives that are simply not true.

Mr. POMEROY. Well, and I don't care about your motive.

Secretary LEAVITT. No. Let me——

Mr. POMEROY. It is the fact, Mr. Secretary.

Secretary LEAVITT. It is not the fact.

Mr. POMEROY. Read your August 31, 2007 rule. This drives us to distraction. You are not a bad man. I have enjoyed knowing you over the years. But the evil effect of impacting a school district like Granite District in Salt Lake City from helping kids that get coverage that need it, to me that is just an evil impact.

Secretary LEAVITT. Do you find it——

Mr. POMEROY. I don't know if it is intended. I don't know what. But I do know that it is extremely bad policy, and this Administration should be ashamed of it. They wrote it, and they would have had it impacted today except for the action of Congress in stopping it.

Secretary LEAVITT. Our time is up. But I will simply say that our purpose is to do nothing but to use wisely the money we have, and that there are districts that abuse the privilege in a way that I don't believe you would feel good about, either.

Mr. STARK. Mr. Ryan. Would you like to inquire?

Mr. RYAN. Thank you, comrade.

[Laughter.]

Mr. Secretary, good to have you here with us again. I had some questions on the trigger and transparency. But I have just been enjoying this conversation.

I just look at the fact that the Medicare Part D bill, law, is coming in about 40 percent under estimates. It is about 40 percent less expensive than we projected it to be. When is the last time Congress passed a program that came in 40 percent under budget? It is because of competition.

You take a look at the Medicaid program, which is not a competitive program, and you have got stories in the Wall Street Journal just a couple days ago where you have one company overcharging Medicaid by $650 million. So, to suggest that only government-run programs that have government monopolies are saving all this money, it just doesn't jive with the facts.

So, I think there is another side of the story from what we have been hearing here, and that choice and competition in the hands of the consumer and among providers actually is proving to work.

Let me ask you two questions, first trigger, then transparency. Give us your assessment on the Medicare 45 percent trigger. When and if do you expect the Administration to respond, and do you care to comment on some suggestions that we might act on in order to conform with the trigger law?

Secretary LEAVITT. First of all, we believe that responding to that trigger is an important discipline that should be followed not only by this Administration but future Administrations. This is a serious problem, and it needs to be responded to.

Second, we will respond, and we will respond within the timeframe allotted in the law, which is 15 days after the President has submitted his budget.

Third, you will see a series of proposals that will, in fact, not just deal with reducing the growth rate in a scorable way, but will also begin to focus on ways we can change the system, not just of Medicare but of health care: basic things dealing with electronic medical records and the efficiencies that can come from that; basic things like measuring quality so that people know what they are getting and have an idea of whether it is good or not; and third, things like cost, so they can actually see the cost and the quality; and providing incentives, not just for consumers but also for the payors and for the plans and for everyone, so that they have a motivation to drive quality up and cost down.

Again, we believe fundamentally that consumers, armed with information, make better decisions than the government makes for them. I think there is a long history to demonstrate that that is true. Part D is just one good example.

Mr. RYAN. So, it sounds like we are on the same page. I hope we do systematic changes that, as responding to the trigger, we do it in such a way that it actually helps the long-term sustainability of Medicare, that it is not simply a price control plan like we did in 1997, where Congress ends up giving all of it back. I hope we do things that are actually systematic, structural, and put us on the right glide path toward making Medicare more sustainable and enhancing its long-term solvency.

Transparency: Give us your take on where the next stage of the transparency movement is. I can just tell you, in Milwaukee, for

example, the price of a bypass surgery ranges from $47,000 to $120,000. The price of an MRI in Milwaukee ranges from $600 to $5,000. The price of rotator cuff surgery, $4,700 to about $15,000. You know, on and on and on. About a 300 percent price disparity among all different kinds of payors, just in the metro Milwaukee market. No one knows this. It took us a couple years just to get that information.

What is the best way to proceed forward in a lasting way to have real transparency, and therefore real competition, based on price and quality?

Secretary LEAVITT. Congressman, I have laid out what I believe are the four cornerstones of such a system.

Mr. RYAN. I apologize if you are repeating yourself. I have been in and out of this hearing.

Secretary LEAVITT. Well, it needs to be repeated many times. Electronic medical records. Quality measures that people can agree upon that are developed by the medical community. Price grouping so that people know what they are paying for. Then motivations and incentives so that people have a reason to care what the costs are and have information about the quality.

Given that kind of information, as we have seen in every other part of our economy, including health care, given that kind of information, people make those decisions. Today Medicare makes a series of decisions, a couple thousand of them, that make those decisions for everyone.

We don't always make the right decision. Oftentimes we are subsidizing pieces of the health care system that we ought not to. Sometimes we are underpaying things that ought to be encouraged. We are not always able to find those. The market will.

Mr. RYAN. So, where prices are visible——

Ms. SCHWARTZ. Excuse me. Would Mr. Ryan yield? I appreciate very much the dialogue that you are having. But isn't it correct that you actually cut the funding for comparative effectiveness research, when in fact we have agreed that that would be helpful; that you did not include an e-prescribing proposal, which many of us in a bipartisan way actually want to see done?

Mr. RYAN. The quick answer is I have one more follow-up.

Ms. SCHWARTZ. Because I think you might agree on that, and it would be great to see it actually included in the budget.

Secretary LEAVITT. No. I am a big supporter of e-prescribing. It is time to do it. It is time to say it has to be done.

Ms. SCHWARTZ. Well, maybe we can get that done.

Mr. RYAN. All right. Well, I see my time is expired.

Ms. SCHWARTZ. But it would have been good to have it be in the budget to start with.

Secretary LEAVITT. I would have liked to have had it done in the SGR fix. I would like to see it happen in June. So, you can't do it soon enough for me.

Ms. SCHWARTZ. Sorry.

Mr. RYAN. That is all right. No problem.

Ms. SCHWARTZ. But I thought if we had a moment of bipartisan agreement, let's see if we can't make it happen. It is not in the budget now. Thank you.

Mr. RYAN. I yield my time on a bipartisan basis.

Mr. STARK. I am going to recognize Mr. Pascrell and Ms. Berkley, who were here ahead. But I am going to ask if you would—we have got 15 minutes till five votes. With the folks that are here, I hope that we could finish up.

Mr. PASCRELL. Mr. Chairman?

Mr. STARK. We have got 12 minutes. I recognize the distinguished gentleman from New Jersey for 3 minutes.

Mr. PASCRELL. Three minutes? Mr. Secretary, thank you for your service. Twenty-five states are about to declare deficits in their budgeting. There will be more coming down the line. I want to remind you of a statement that you made in 1999, when you were the governor of Utah. You sent a letter to the Congress of the United States, and this is what you said in that letter.

"Reductions in the funding for social services block grants will result in cuts to vital human services for our most vulnerable citizens." This President, in his proposal, is nothing more—is cutting more than $1.7 billion annually in the services that are most needed.

If you were in a governor's position, which you were, and you did a very good job when you were the governor of Utah, you would have a different attitude in supporting this budget before us.

I want to get into a very specific area which affects New Jersey particularly, and that is the area of teaching hospitals. I think that this borders on criminal. The proposal before us will damage our ability to train a generation of new doctors at a time when the nation is facing a shortage of doctors. This is exactly the opposite direction which we need to move.

In fact, today I, along with my colleague and fellow Committee Member Congressman Ron Lewis, introduced legislation that will bring equity to a deficient Medicare compensation formula for direct graduate medical education currently used to reimburse teaching hospitals.

More than 600 American hospitals are being reimbursed by Medicare at an inadequate level for their work in training America's doctors of tomorrow. These costs bear little if any relationship to the actual costs of operating the training program in the 21st century. I was going to give you anecdotal evidence; I think you know the evidence.

In New Jersey alone, our teaching hospitals have lost close to $7 million. When you combine a broken DGME payment system with the draconian indirect medical education cuts that you are proposing contained in this budget, I am extremely concerned that these unsustainable losses will threaten the future of this nation's health care infrastructure.

Under these circumstances, at a time when we need more doctors, not less, how are teaching hospitals to fulfill their mission, Mr. Secretary?

Secretary LEAVITT. First let me acknowledge the 1999 letter. I have had it read to me enough times now, I could probably quote it.

But I would like to acknowledge that there is one fundamental difference between 1999 and now. We had a balanced Federal budget then. We don't now. Obviously, a lot of circumstances are different.

Mr. PASCRELL. I am very aware we had a balanced budget then.

Secretary LEAVITT. I am sure you are.

Mr. PASCRELL. Yes. Very aware.

Secretary LEAVITT. I just point out the difference.

With respect to the teaching hospitals, I know and you know how vital it is to have vital teaching hospitals. I will tell you I think the system of the way we finance it is "skiwampus." It ought to be spread over a much greater part. The Federal Government does a substantial part of it. We ought to spread the base.

Mr. PASCRELL. But there is nothing in this proposal, in this budget, that addresses that issue. You have had 300 hospitals close in the last decade.

Mr. STARK. We will get to that, Mr. Pascrell.

Now we are going to get to Ms. Berkley, who is going to be recognized for 3 minutes.

Ms. BERKLEY. Thank you very much for coming. I wish we had a little more time. I know that you have family that lives in my congressional district.

Secretary LEAVITT. I do, yes.

Ms. BERKLEY. I met with them very recently. So, let me tell you about the community that they are living in right now. I am going to restrict my comments to SCHIP, Medicare, and Medicaid. We have a serious health care crisis in the state of Nevada. I think this budget is going to exacerbate the problem. Let me tell you why.

I have got the fastest growing senior population in the United States. I have got doctors that are calling me, not in a threatening way, but telling me that they will keep the Medicare patients that they have, but they can no longer accept new ones. Right now they are losing money.

If what is in this budget, with the fee schedule, the physicians fee schedule—if we don't restore the money, they are going to take a considerable hit. Short of me going to medical school and learning how to treat my senior citizens, there is not going to be any health care for them. That is going to be disastrous. That is number one.

Number two, SCHIP. There are 70,000 kids that are eligible for SCHIP under the current regulations and income levels. We only can service, with the money we get now, 29,000. Without increasing the SCHIP program, I have got approximately 40,000, 41,000 kids that are eligible as we speak that aren't getting the health care that they should be getting from us, from this incredibly wealthy country.

Third, Medicaid. Medicaid is in crisis in the state of Nevada. With serious budget shortfalls on the state level, the fact that we are moving to a 50 percent rather than a 52 percent match with Federal dollars is going to have devastating consequences to the poor people in my state that rely on Medicaid for health care.

What can you do to help me to care for the people that I represent? Yes, we are going to need to make some long-term changes to Medicare so it will continue. But I am also talking uninsured. A third of the people that I represent are uninsured.

I have got SCHIP issues, with 40,000 eligible kids not getting it. Medicaid is in crisis because there is no money now and there is

going to be less later if this budget goes through. Medicare, I have got seniors that are dying for a lack of health care because I have got a doctor shortage.

So, what do I do? What do you do to help me do my job?

Secretary LEAVITT. In the 17 seconds we have left, let me just deal with SCHIP. You have probably seen in the President's budget that he has proposed just under $20 billion. That would fund those who are eligible for SCHIP and all those that the states have indicated to us they expect to be needed. So, that is one thing.

Ms. BERKLEY. Excuse me one minute. Let me tell you, I spoke to our administrator of SCHIP, not of my party, who told me she is capping at 30,000. We have 70,000 kids that are eligible right now. She is going to cap it. We have got 29; she is capping at 30. I have got 40,000 kids that aren't going to get health care.

Secretary LEAVITT. I am guessing if the President's budget passed, she would change that view.

Mr. STARK. We have just a few minutes. I wanted to recognize Mr. Nunes for a unanimous consent request, to be followed by Mr. Porter, who I will recognize for 3 minutes.

Mr. NUNES. Thank you, Mr. Chair. Due to the time constraints, I have a statement that I would like to submit for the record.

Mr. STARK. Without objection, it will be included in the record and sent to the Secretary.

Mr. NUNES. Thank you.

[The prepared statement of Mr. Nunes follows:]

[The statement was not received in time for publication.]

Mr. STARK. Mr. Porter, you have 3 minutes to conclude our hearing.

Mr. PORTER. Thank you.

Mr. STARK. I will thank you now. We are going to go off for a vote. At the conclusion of Mr. Porter's inquiry, Mr. Secretary——

Secretary LEAVITT. Thank you for being here.

Mr. STARK [continuing]. Our thanks to you for your patience and courtesies. We will be seeing more of you over the next few months.

Secretary LEAVITT. Thank you.

Mr. STARK. Mr. Porter.

Mr. PORTER. Thank you, Mr. Chairman. I appreciate the opportunity. Mr. Secretary, I will be very brief.

There was a plan just a few months back that would have cut benefits to 9 million beneficiaries in Medicare under the Medicare Advantage program. It was a $160 billion cut. Forty thousand seniors in my district would have lost or reduced their benefits, I believe, in the largest cut in Medicare benefits in the history of the country.

Again, that was a few months ago. I realize that we are fortunate in Nevada that the plan did not pass because it would have impacted over 100,000 seniors in Nevada. What would the 9 million beneficiaries in Medicare have done had the Democrats' plan of cutting $160 billion from Medicare—what would they have done, these 9 million beneficiaries?

Secretary LEAVITT. Well, those 9 million made a change to Medicare Advantage because it was better for them, and in most cases they got better benefits. They could find a doctor more easily.

There were particular areas where there were low income populations as well as minority communities that just love Medicare Advantage.

Mr. PORTER. Mr. Secretary, I had hundreds of calls from seniors, dozens of letters from seniors, that had trouble paying their bills, meeting their rent, putting food on their table. This Congress considered cutting off their benefits. I personally think it is appalling.

But I know we are here today to talk about a future budget. But looking back, that would have had a major impact on Nevada families. I appreciate what you are doing. Thank you.

Secretary LEAVITT. Thank you.

Mr. STARK. Thank you all for your patience and your courtesy and your cooperation. Thank you, Mr. Secretary.

Secretary LEAVITT. Thank you.

Mr. STARK. The hearing is adjourned.

[Whereupon, at 3:49 p.m., the hearing was adjourned.]

[Questions for the Record follow:]

Questions For the Record for HHS Secretary Leavitt

Question from Mr. Van Hollen

Mr. Secretary, in your written testimony before the Committee, you briefly discuss the FY 2009 budget for the National Institutes of Health (NIH). You state the overall FY 2009 budget for the NIH will be the same as FY 2008. This continues a disturbing trend by the Administration of flat-funding the NIH since the successful five year doubling of the NIH budget ended in 2003. By flat-funding the NIH budget, it does not keep up with medical inflation and will cause the NIH to lose the momentum and innovation it has gained in finding new treatments and cures for many diseases. And we will forfeit the opportunity to make important and cost-effective advances in many areas of health. NIH Director Elias Zerhouni recently expressed his concern about continued flat funding of the NIH at a November 2007 medical research conference sponsored by PhMRA and Research! America, and I quote, "What's the sense of saying you really want to double research, and then cut it every year by a little bit, little bit, a little bit?" Can you explain why the Administration proposes to yet once again flat fund the budget for NIH in light of the concerns expressed by its Director?

Questions from Ms. Schwartz

Comparative Effectiveness funding

Many experts in budgets and health care declare that "Comparative Effectiveness Research" will help us reduce health care costs and improve outcomes. I agree, and think that comparative effectiveness research holds a lot of promise. Based on the economic report from the Administration this week, it appears that you agree:

"One of the key impediments to more effective health care delivery is a lack of relevant information—for patients, providers, and payers—on the comparative effectiveness and efficiency of health care options. Such information would be particularly useful for services that are in common practice, generate high costs, employ rapidly changing technologies for which multiple alternative therapies exist, and are in areas with substantial uncertainty. The wide geographic variations in the use of procedures suggest that better information on the effectiveness of different styles of medical practice could result in substantial cost savings."

Why then would the President's budget cut funding for comparative effectiveness research and the Agency for Health Research and Quality (AHRQ) by $9 million?

Electronic Prescribing

On the issue of cost-savings in Medicare, as you may know, I am an avid supporter of electronic prescribing. Wide-spread use of e-prescribing has the potential to save hundreds of lives and produce billions in savings. In fact I have proposed legislation to promote wider use of electronic prescribing in Medicare. I would have hoped that your

administration would have taken this sort of approach to proposed reforms to Medicare in the budget recommendations, as opposed to across the board cuts. Does the administration agree that there is indeed a need for providers in Medicare to come up to speed with technology and incorporate technologies like e-prescribing into their everyday practice?

Medicare Hospital Cuts

There is consensus among health financing experts that Medicare's long-term financial sustainability must be addressed with thoughtful and comprehensive reform. Yet, the cuts to providers included in the President's budget proposal suggest he was neither thoughtful nor thorough in his recommendations, and specifically with hospital reimbursement.

Hospitals in my district, which depend on Medicare, are working on razor thin margins already. If we implemented the President's budget recommendations, hospitals in Southeast Pennsylvania alone stand to lose will face cuts of $226 million in 2009, and $2.1 billion over the next five years – these just aren't sustainable given the populations we serve.

Isn't it likely that freezing payment rates will merely lead these hospitals to find ways to shift costs to other payers? Did the Administration conduct any rigorous analysis of how these hospital cuts would affect access to care and the potential of hospitals having to shut their doors?

Bill Powell
13 Feb 2008

Questions for Secretary Leavitt –

Compendia – for the record
Patients in many parts of our country are being denied access to lifesaving therapies because the list of approved compendia in Medicare Part B has fallen into disrepair.

Last Wednesday, CMS posted an announcement on its website about its intention to officially remove the AMA Drug Evaluations Compendium (AMA-DE) from the list of approved compendia.

This move is understandable, because the AMA-DE compendium hasn't been updated since 1996 when it merged with one of the other three approved compendia, USP-DI. But USP-DI has since changed ownership and changed its name to DrugPoints and isn't being recognized by local Medicare carriers. **Therefore, for many years there has only been one functioning compendia, AHFS-DI. One compendium is not nearly enough to make the system function for all patients.**

When CMS announced the removal of AMA-DE last week, the agency stated, "We believe that the deletion of the AMA-DE is necessary to ensure that Medicare contractors and public stakeholders rely on up to date authoritative resources on off-label anticancer chemotherapeutic treatment regimens."

Mr. Secretary, **if CMS' goal is to ensure that patients and providers have up to date compendia at their disposal,**

doesn't it make sense that CMS should start adding additional, up-to-date compendia so patients can get the access they need right now? These people, especially cancer patients, need the access to these drugs immediately.

[Responses to Questions for the Record follow:]

House Ways & Means QFR Responses

Chris Van Hollen

Question:

1. Mr. Secretary, in your written testimony before the Committee, you briefly discuss the FY 2009 budget for the National Institutes of Health (NIH). You state the overall FY 2009 budget for the NIH will be the same as FY 2008. This continues a disturbing trend by the Administration of flat-funding the NIH since the successful five year doubling of the NIH budget ended in 2003. By flat-funding the NIH budget, it does not keep up with medical inflation and will cause the NIH to lose the momentum and innovation it has gained in finding new treatments and cures for many diseases. And we will forfeit the opportunity to make important and cost-effective advances in many areas of health. NIH Director Elias Zerhouni recently expressed his concern about continued flat funding of the NIH at a November 2007 medical research conference sponsored by PhRMA and Research! America, and I quote, "What's the sense of saying you really want to double research, and then cut it every year by a little bit, little bit, a little bit?" Can you explain why the Administration proposes to yet once again flat fund the budget for NIH in light of the concerns expressed by its Director?

Response:

Tight budgets require us to make tough choices for biomedical research; we've been making such choices since FY 2003, the last year of the doubling.

The Budget's funding priorities are sound. Individual research grants remain the mainstay of NIH, and research will still be awarded competitively. The overall FY2009 President's Budget will support over 38,000 research project grants, including more than 9,700 new and competing awards.

We will continue to invest whatever funds Congress provides to NIH in the best science, and help speed the translation of scientific advances into therapies, cures, and diagnostics as quickly as resources will allow.

Allyson Schwartz

Question

1. Comparative Effectiveness funding

   Many experts in budgets and health care declare that "Comparative Effectiveness Research" will help us reduce health care costs and improve outcomes. I agree, and think that comparative effectiveness research holds a lot of promise. Based on the economic report from the Administration this week, it appears that you agree:

   "One of the key impediments to more effective health care delivery is a lack of relevant information—for patients, providers, and payers—on the comparative effectiveness and efficiency of health care options. Such information would be particularly useful for services that are in common practice, generate high costs, employ rapidly changing technologies for which multiple alternative therapies exist, and are in areas with substantial uncertainty. The wide geographic variations in the use of procedures suggest

that better information on the effectiveness of different styles of medical practice could result in substantial cost savings."

Why then would the President's budget cut funding for comparative effectiveness research and the Agency for Health Research and Quality (AHRQ) by $9 million?

Response:
HHS is presently undertaking a number of activities to ensure that better information on medical costs and practices are available to consumers and providers in order to help reduce health care costs and improve patient outcomes. One component of this is AHRQ-supported research on different therapies to provide patients and providers with evidence-based information to help them make informed choices about different health care options. I am pleased that the Congress approved doubling AHRQ's budget for comparative effectiveness research in FY 2008 and that the President's budget continues the funding for this type of research in FY 2009. In addition, the Department is moving aggressively to share information on price and quality in health care so that consumers have this information and can make better decisions. Consumers should share in the savings, in the form of lower premiums and more effective care, when they take an active role in health care decisions.

Question
2. Electronic Prescribing
On the issue of cost-savings in Medicare, as you may know, I am an avid supporter of electronic prescribing. Wide-spread use of e-prescribing has the potential to save hundreds of lives and produce billions in savings. In fact I have proposed legislation to promote wider use of electronic prescribing in Medicare. I would have hoped that your administration would have taken this sort of approach to proposed reforms to Medicare in the budget recommendations, as opposed to across the board cuts. Does the administration agree that there is indeed a need for providers in Medicare to come up to speed with technology and incorporate technologies like e-prescribing into their everyday practice?

Response:
The administration strongly supports broader adoption of e-prescribing, and we have been working toward that end for several years now. Within the Medicare program specifically, the Centers for Medicare & Medicaid Services (CMS) has taken a leadership role in the ongoing development of uniform standards for electronic-prescribing for the Medicare Part D program.

Since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS has been working with its government partners and industry stakeholders to develop and implement standards that will create an e-prescribing infrastructure that will allow us to realize the significant potential public health and safety benefits that e-prescribing offers for the Medicare part D eligible population. The MMA directed CMS to promulgate standards for a Medicare Part D e-prescribing program. Part D sponsors are required to support the standards adopted under that program, and prescribers and dispensers are required to utilize the standards if they choose to conduct e-prescribing. For several years now, CMS has pursued an incremental approach to adopting final uniform standards for Part D e-prescribing that are consistent with the MMA's objectives of patient safety, quality, and efficiency. Beyond Part D, facilitating the widespread adoption of e-prescribing is one of the key action items in the Administration's effort to build a nationwide, interoperable electronic health information infrastructure.

CMS also continues to invest in innovative research and demonstration projects to help slow the rapid growth of health care spending and improve the efficiency and quality of our health care programs. A five-year demonstration project is aimed at promoting high-quality care through the adoption and use of electronic health records (EHRs). The demonstration is to be implemented in approximately 1,200 small- to medium-sized primary care physician offices in up to twelve sites. Under the demonstration, practices will be eligible to earn incentive payments for the implementation and adoption of health information technology in their practice and achieving specified standards on clinical performance measures for diabetes, congestive heart failure, coronary artery disease and the provision of preventive health services. The demonstration is an important step towards meeting the President's goal of nationwide adoption of EHRs by 2014.

Question

3. Medicare Hospital Cuts

There is consensus among health financing experts that Medicare's long-term financial sustainability must be addressed with thoughtful and comprehensive reform. Yet, the cuts to providers included in the President's budget proposal suggest he was neither thoughtful nor thorough in his recommendations, and specifically with hospital reimbursement.

Hospitals in my district, which depend on Medicare, are working on razor thin margins already. If we implemented the President's budget recommendations, hospitals in Southeast Pennsylvania alone stand to lose will face cuts of $226 million in 2009, and $2.1 billion over the next five years – these just aren't sustainable given the populations we serve.

Isn't it likely that freezing payment rates will merely lead these hospitals to find ways to shift costs to other payers? Did the Administration conduct any rigorous analysis of how these hospital cuts would affect access to care and the potential of hospitals having to shut their doors?

Response:

Hospitals account for a significant portion of Medicare spending and an even greater percentage of spending for the Hospital Insurance (HI) Trust Fund, which is currently expected to become insolvent in 2019. The Administration believes that we need to achieve savings and program efficiencies in hospital and other Medicare services and improve the long-term solvency of the HI Trust Fund.

Additionally, hospitals have historically demonstrated that they can reduce costs without hindering access. Maintaining 2008 payment levels through 2011, as the President's budget proposes, will only spur hospitals to increase their efficiency without seriously impairing access to care. MedPAC noted in its January 2008 meeting that all indicators of payment adequacy were positive for hospitals. Strong beneficiary access to hospitals, increases in hospital service volume, and significant access to capital for expansion and construction indicate that hospitals are continuing to perform well while participating in the Medicare program.

Bill Pascrell

Question

1. Compendia – for the record

Patients in many parts of our country are being denied access to lifesaving therapies because the list of approved compendia in Medicare Part B has fallen into disrepair.

Last Wednesday, CMS posted an announcement on its website about its intention to officially remove the AMA Drug Evaluation Compendium (AMA-DE) from the list of approved compendia.

This move is understandable, because the AMA-DE compendium hasn't been updated since 1996 when it merged with one of the other three approved compendia, USP-DI. But USP-DI has since changed ownership and changed its name to DrugPoints and isn't being recognized by local Medicare carriers. Therefore, for many years there has only been one functioning compendia, AHFS-DI. One compendium is not nearly enough to make the system function for all patients.

When CMS announced the removal of AMA-DE last week, the agency stated, "We believe that the deletion of the AMA-DE is necessary to ensure that Medicare contractors and public stakeholders rely on up to date authoritative resources on off-label anticancer chemotherapeutic treatment regimens."

Mr. Secretary, if CMS' goal is to ensure that patients and providers have up to date compendia at their disposal, doesn't it make sense that CMS should start adding additional, up-to-date compendia so patients can get the access they need right now? These people, especially cancer patients, need the access to these drugs immediately.

Response:
We understand the importance of recognizing additional Part B drug compendia but also the need to establish a regular, timely and transparent process for consideration of additional compendia. Therefore, in the November 2007 physician fee schedule final rule CMS established a sub-regulatory annual process for making changes to the list of compendia for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. The CMS annual process involves:

- CMS accepting requests for changes to the Part B drug compendia list during a 30 day period. Beginning on January 15th of a given year. (requests would be submitted by February 15th).

- CMS publishing a listing of the timely, complete requests received on its websiteby March 15th, and allowing the public 30 days to submit comments on the requests (by April 15th)

- CMS requiring that a complete request contain specific information identified in the final rule.

- CMS evaluating how well a proposed compendium achieves desirable characteristics of compendia that were recommended by a special advisory panel.

- CMS publishing a decision on its website within 90 days after the close of the public comment period (i.e., by July 15th).

The annual process for 2008 is occurring ahead of schedule because of: (a) proactive CMS interactions with the stakeholder community during the period leading up to January 15; (b) timely submission of requests; (c) CMS' prompt initial review of requests for completeness; and (d) CMS' posting of the requests for the 30 day public comment period as soon as our initial review was complete. CMS has posted four requests for public comments: one on February 6th, 8th, 12th and 19th, respectively. The comment periods for these requests close on March 7th, 9th,

13th, and 20th., respectively. The requests can be found on the CMS website at http://www.cms.hhs.gov/mcd/index_list.asp?list_type=mcd_6. In addition to the annual process, CMS may internally generate a request for changes to the list of compendia at any point in time to protect the interest of the Medicare program and its beneficiaries. For example, CMS received a fifth request after the 30 day period, and has decided to review it in light of the public interest on this topic. The fifth request was posted on March 4th and the comment period closes on April 3rd.

After the comment periods end, CMS will publish decisions as soon as the evaluation process has been completed but no later than 90 days after the close of the comment periods (which occur in June 2008 for four requests and July 2008 for the fifth). CMS could announce decisions earlier if the evaluation is completed earlier than the end of the 90-day period.

Once CMS publishes the decisions on its website, we expect that contractors who pay Medicare claims would immediately utilize the newly approved compendia. The use of newly-approved compendia will not be delayed until 2009.

[Submissions for the Record follow:]

Statement of Puerto Rico Hospital Association

Today, we want to respectfully express our concerns with the President's fiscal year 2009 budget proposal. We feel the proposed legislation lacks sound solutions to the problems and challenges we are facing. Further, we have serious concerns with the impact this proposed budget will have on the quality of health care services provided by hospitals, not just in Puerto Rico, but in the U.S. mainland. It is very difficult to envision how this proposal will put us in a better position to discharge our responsibility to provide the quality health care needed by individuals and families.

The Puerto Rico Hospital Association (PRHA) is a private not-for-profit association representing over 90 percent of all private and public hospitals in Puerto Rico as well as other institutions or entities interested in the field of health. PRHA was founded in 1942 with the purpose and mission of maintaining excellent health care standards in our industry for the benefit of our community.

Our organization has actively lobbied the U.S. Congress for the past two decades, highlighting the Island's unequal treatment in major Federal health care entitlement programs such as Medicare, Medicaid and SCHIP. This severe lack of funding impacts the Island's health care industry as a whole. Puerto Rico loses anywhere from 1.5 to 2 billion in health care funds every year because of the Island's discriminatory treatment in these vital programs.

Specifically, under the PPS, hospitals in Puerto Rico are reimbursed under a special formula consisting of 75% of the national share and 25% of the local rate share (compared to the 100% national average for hospitals located in the 50 states). This unequal treatment to hospitals on the Island has been maintained despite the fact that the U.S. citizens of Puerto Rico pay the same Medicare payroll taxes and deductibles as their fellow citizens in the 50 states. Also, Puerto Rico hospitals are required to comply with the same Medicare standards of participation as hospitals on the mainland.

Furthermore, hospitals in the 50 states receive reimbursement adjustments under the Medicare Disproportionate Share (DSH) program for providing essential health care to a disproportionately large number of low-income patients. Because the U.S. citizens of Puerto Rico are not entitled to SSI benefits, current Federal law results in the inaccurate conclusion that hospitals on the Island do not treat any low-income Medicare beneficiaries. As a matter of fact, nearly 50% of Medicare beneficiaries in Puerto Rico are Medicaid eligible—compared with only 12% in the 50 states.

It is quite unfortunate that the President's budget fails to address any of the aforementioned discrepancies, which are forcing thousands of senior citizens on the Island to move to the U.S. mainland in search of better quality and more accessible health care. It is our sincere hope that we can all work together as a nation to craft legislation that will benefit the country as a whole without leaving the 4 million U.S. citizens of Puerto Rico out of the equation.

Statement of The Senior Citizens League

On behalf of the approximately 1.2 million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding the President's Fiscal Year (FY) 2009 Budget for the U.S. Department of Health and Human Services (HHS). TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

In 2003, legislation that overhauled Medicare included a provision that requires the President to propose changes to Medicare in the event that the entitlement was going to draw more than 45 percent of its funding from the government's general revenue instead of the Medicare Trust Fund. This finding occurred in 2006 and 2007, and in the President's proposed budget for fiscal year (FY) 2009, Medicare spending is reduced by $12.2 billion in FY 2009 and by $178 billion over five years. It is not clear at this time if there will be additional proposals.

While TSCL fully understands the need to address the looming Medicare Trust Fund exhaustion, we are concerned that it may come at the expense of Medicare beneficiaries, many of whom are already financially strapped due to high premiums and an inadequate cost of living adjustment (COLA) to their Social Security benefits. Since 2000, Social Security benefits have increased 22%, and Part B premiums have increased 111%.

The 2009 Budget includes several legislative proposals that the Administration believes could strengthen the longevity of the Medicare entitlement program, if signed into law. The proposals would: "encourage provider competition, efficiency, and high-quality care; rationalize payment policies; increase beneficiary responsibility for health care costs, improve Medicare's fiscal sustainability, and improve program integrity." [1]

Encourage Provider Competition, Efficiency, and High-Quality Care

TSCL agrees that reform is needed when it comes to provider reimbursement, especially in the case of physicians providing outstanding care to Medicare beneficiaries. In recent years, premiums have been announced prior to increases in physician reimbursements, meaning that actual program costs are higher than originally estimated. Although temporary fixes have been issued, TSCL is concerned that with the "trigger," proposals could eventually lead to a substantial jump in Part B premiums to offset the rising cost of quality health care.

Last year, the Medicare Trustees estimated that Medicare Part B and Part D premiums, deductibles, and coinsurance costs were taking one-third of the average Social Security benefit. Skyrocketing premiums, accompanied with a COLA that does not take adequately into account health care expenses are making it difficult for many seniors, especially those relying solely on their Social Security benefits, to get by. We should note, however, that TSCL and its members were pleasantly surprised with a Part B premium increase of $2.90 per month in 2008 for the majority of seniors.

Increase Beneficiary Responsibility

Increasing beneficiary responsibility on the surface may sound like a good idea to some. TSCL is concerned about the proposal to eliminate the annual indexing of income thresholds for Medicare Part B premiums, especially if Part D becomes subject to the same income thresholds.

We fear that halting the annual index for income related premiums will lead to more and more middle-income seniors paying higher rates. Although some advocates consider it to be fair for those with higher incomes, we fear that low- and middle-income seniors will be the ones to suffer and eventually end up paying higher premiums as the threshold is lowered to make up for future funding shortcomings. Further, it seems unjust to have a group of beneficiaries paying more for the same care and coverage. As the snowball grows, more seniors could look outside of Medicare plans for quality health care insurance at a lower cost.

TSCL also questions how private entities will be able to implement income indexing accurately. With the involvement of private companies, the Internal Revenue Service, and the Social Security Administration, the automatic deduction of premiums from monthly benefits could become more costly and onerous. It seems that the only way means testing could work for Medicare Part D is to consider eliminating private insurance companies from the equation, leaving Medicare to coordinate Part D as it does Part B.

Improve Program Integrity

Greater program oversight is always a welcomed proposal. As reported in the new 2009 Budget in Brief, the Health Care Fraud and Abuse Control (HCFAC) program is responsible for detecting and preventing health care fraud, waste, and abuse. This is accomplished through investigations, audits, educational activities and data analysis. From 1997 to 2007, HCFAC returned more than $10 billion to the Medicare Trust Fund. While this is impressive, we can only imagine how much more money could be saved and/or returned with a more streamlined process among the involved agencies.

Equipping health care providers with knowledge about problems and ways to increase accuracy will undoubtedly save money. As reported for 2007, improper Medicare payments have dropped to a new low of 3.9 percent. TSCL supports strong enforcement and greater audits of claims, especially when considering the problems occurring with Part D plans.

Also, it has been widely reported that the Medicare payment system should take a closer look at excessive payments for certain items. The New York Times has reported that Medicare pays much higher amounts for durable medical equipment than are charged to individuals buying the same product.[2] According to the 2007 NYT article, ". . . Even for a simple walking cane, which can be purchased online

[1] www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf, p. 53–54.

[2] Duhigg, C., "Oxygen Suppliers Fight to Keep a Medicare Boom," New York Times, Nov. 30, 2007.

for about $11, the government pays $20, according to government data." Another example of overspending occurs when the government rents oxygen equipment for up to 36 months at a cost of more than $8,000 per individual. The article reports that the same equipment could be purchased from a retailer for "as little as $3,500."

TSCL is not suggesting that oxygen equipment not be provided for those in need. What we do believe is that there are more fiscally responsible ways to provide the same care, which in the end could save Medicare billions of dollars annually.

Conclusion

Although we are pleased that the Administration has put together suggestions for strengthening the Medicare Trust Fund, TSCL and its members are concerned about what the cost to the public will be. While we do not have a perfect solution, there are some simple actions that could be taken in the meantime.

For example, TSCL is encouraging all Members of Congress to support a recently introduced bill, H.R. 4338, introduced by Rep. Timothy Walberg (MI–7). H.R. 4338, titled the Social Security and Medicare Lock-Box Act, would establish a procedure to safeguard the surpluses of the Social Security and Medicare hospital insurance trust funds. Thanks to Rep. Stephanie Tubbs Jones (OH–11), an original co-sponsor, this legislation had bi-partisan support from the start. Additionally, similar legislation, S. 302, was introduced last year during the first session of the 110th Congress by Senator David Vitter (LA).

As the Administration suggests, tougher enforcement and increased transparency will save Medicare billions of dollars annually. A significant portion of the expenditures comes from fraud and abuse that hurts the solvency of important entitlement programs like Medicare for current and even future retirees.

Regardless of which solution Members of Congress believe is best, TSCL sincerely hopes that the Medicare and Social Security Trust Funds are protected and strengthened for future generations.